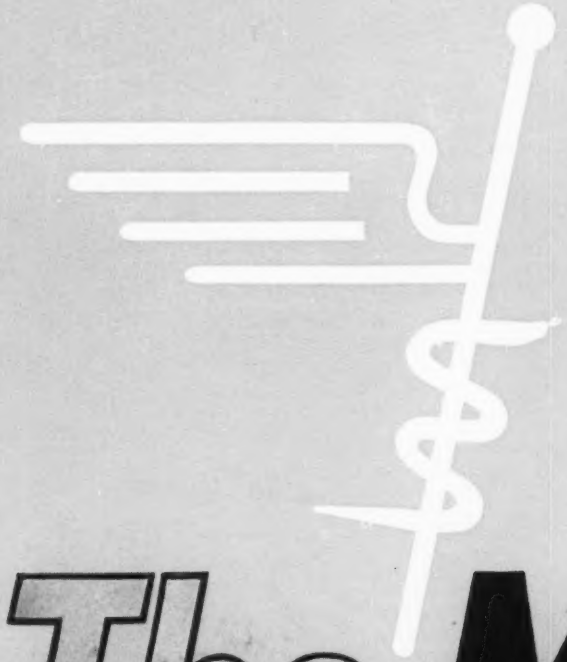


The Modern Hospital

JANUARY 1954

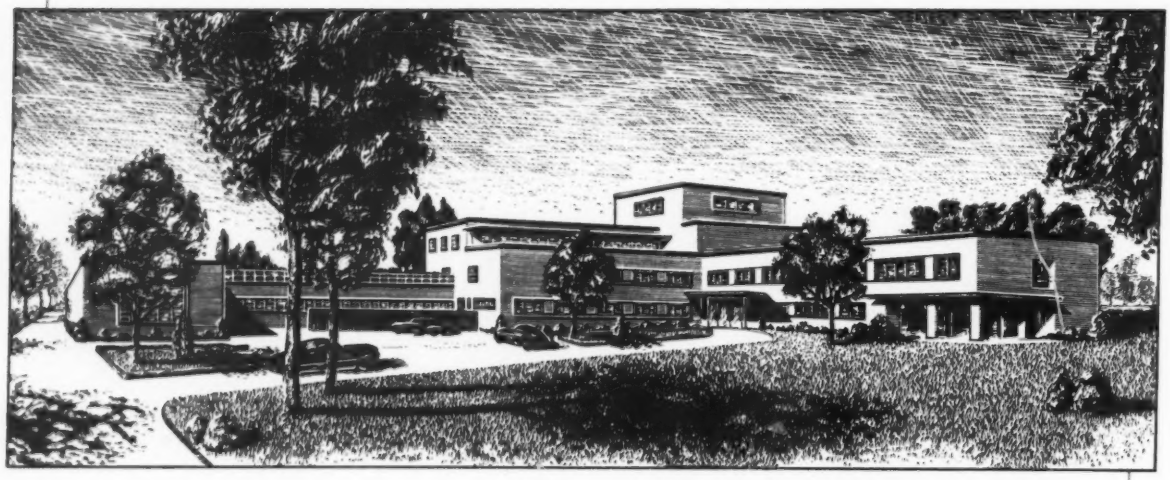
Who Should Do Surgery? • Geriatrics in the General Hospital • New A.M.A. Statement on Doctor-Hospital Relations • Prototype Study 200 bed Hospital • Depreciation in Hospital Accounting • Home Care Program • Seattle's Children's Hospital

IN MODERN HOSPITALS...

SAFETY, COMFORT, ECONOMY

WITH

JOHNSON AUTOMATIC TEMPERATURE CONTROL



Jane G. Phillips Memorial Hospital, Bartlesville, Oklahoma. Neville, Sharp and Simon, architects, Kansas City, Mo.; Wm. L. Cassell, mechanical engineer, Kansas City, Mo.; J. L. Heath Co., heating and air conditioning contractors, Tulsa, Oklahoma.

Comfort and health of Jane G. Phillips Memorial Hospital's patients are constantly guarded by Johnson *Individual Room* Thermostats which operate individual room air conditioning units to provide precisely the proper temperatures. The temperatures and humidities in air conditioned operating rooms, delivery rooms and other vital areas are also controlled by Johnson.

This Johnson *Planned-for-the-Purpose, Installed-for-the-Purpose* Control System, throughout the entire hospital, provides greater comfort and faster recovery for patients, permits personnel to concentrate on professional duties and insures the greatest return on every dollar spent for heating and cooling.

But, above all else, because it is *pneumatically* operated, Johnson apparatus meets the most exacting hospital safety requirements. It is completely safe even where there are explosive anesthetic gases. Johnson Humidity Control guards against the dangers of static electricity.

Whether you are planning the regulation of temperatures and humidities in a single operating room or an entire hospital, large or small, old or new, ask an engineer from the Johnson nationwide staff to talk over the desirable features and economy of a Johnson System of Automatic Control. There is no obligation. JOHNSON SERVICE COMPANY, Milwaukee 2, Wisconsin. Direct Branch Offices in Principal Cities.

D-251 Piston Damper Operator

T-900 Master Thermostat

T-901 Submaster Thermostat

V-108 Three-way Mixing Valve

JOHNSON *Automatic Temperature and Air Conditioning* **CONTROL**

MANUFACTURING • PLANNING • INSTALLING • SINCE 1885

The Modern Hospital

EDITOR: ROBERT M. CUNNINGHAM JR.

TECHNICAL ADVISER: EVERETT W. JONES

ASSOCIATE EDITORS: MILDRED WHITCOMB, JANE BARTON

EDITORIAL ASSISTANT: BARBARA STERRETT

PUBLISHER: RAYMOND P. SLOAN

ASSOCIATE PUBLISHER: STANLEY R. CLAGUE

ADVERTISING DIRECTOR: J. W. CANNON JR.

JANUARY 1954

Published monthly and copyrighted, 1954. The Modern Hospital Publishing Company, Inc., 919 North Michigan Avenue, Chicago 11, Ill., U. S. A. (Cable Address: Modital, Chicago.) Otho F. Ball, M.D., president; Raymond P. Sloan, vice president; Everett W. Jones, vice president; Stanley R. Clague, secretary; John P. McDermott, treasurer. Subscription price: $3 a year; overseas, $5 a year. Single copies, 50 cents; back copies, $1. Member, Audit Bureau of Circulations. Entered as second-class matter, Oct. 1, 1918, at the post office at Chicago, Ill., under act of March 3, 1879. Printed in U. S. A. Eastern Office, 101 Park Avenue, New York 17, N. Y. Cleveland Office, 1501 Euclid Ave., Cleveland 15, Ohio. Pacific Coast Representatives, McDonald-Thompson, Los Angeles, San Francisco, Seattle, Dallas, Portland, Denver.

AMONG THE AUTHORS

Dr. Robert S. Myers in his article on page 51 enumerates surgical standards approved by the American College of Surgeons. Dr. Myers, who formerly practiced medicine in Boston, is administrative assistant of the American College of Surgeons. After graduating from the Harvard Medical School, Dr. Myers served his internship and residency at Peter Bent Brigham Children's Hospital in Boston. He is a fellow of the American College of Surgeons, a member of the Norfolk County Medical Society and the Massachusetts Medical Association. Dr. Myers is also a member of the American Medical Association.

Lee O. Garber, associate professor of education at the University of Pennsylvania, brings to the hospital field the report of a Florida court that decided a doctor does not have an inherent right to practice in a private hospital (*p.* 69). In addition to teaching, Mr. Garber is editor and distributor of the "Yearbook of School Law." Mr. Garber received his bachelor's degree from Illinois Wesleyan University, his master's from the University of Illinois, and his Ph.D. from the University of Chicago. His legal training was taken at Bloomington Law School, Bloomington, Ill. Before accepting his present position, he held several professorships and had spent two years as an educational relations specialist for the Tennessee Valley Authority.

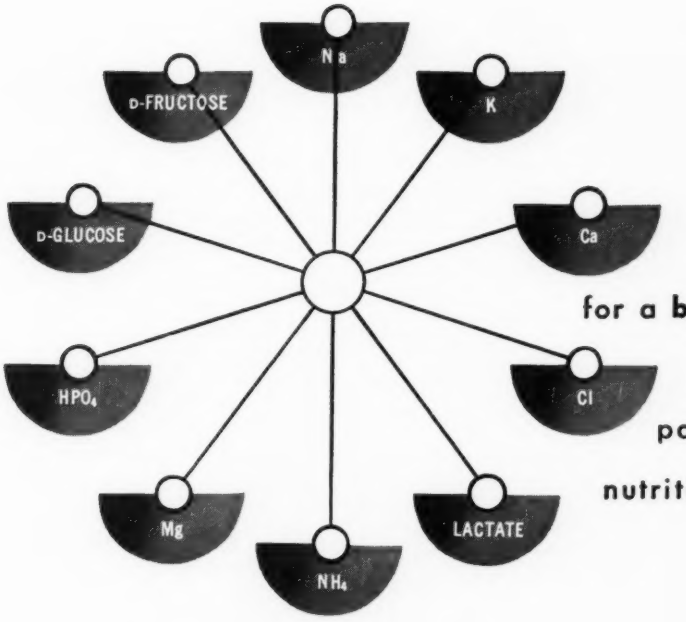

Mark Berke

Mark Berke, a former London chiropodist with an interest in accounting, is the author of an article on patient transportation service at Mount Zion Hospital, San Francisco, where he is administrator (*p.* 88). In 1943 Mr. Berke joined the staff of the accounting department of the Hospital for Joint Diseases, New York City, where he spent two years before going to Mount Sinai Hospital of Cleveland as controller. While there he became administrative assistant and then assistant director. In April 1951, Mr. Berke went to Mount Sinai Hospital of Philadelphia as administrator. He moved to San Francisco in the fall of 1952.

Janet Watson Brady, public relations director at Children's Orthopedic Hospital, Seattle, has presented a vivid description of the architecture and layout of the hospital (*p.* 63). Mrs. Brady is a former newspaper woman with a background including radio experience. She was the producer and writer of her own sponsored radio program. In World II she served as Washington State director of press, advertising and radio for the United States Treasury Department, War Bond Division. The hospital's public relations program has been handled by Mrs. Brady for the last six years and won national honors in 1950.


Jane Hartman

Jane Hartman, food service director of Maryland State Department of Health, aids small hospitals in setting up therapeutic diets (*p.* 112). She was joint author of a series of four food service articles which appeared in The Modern Hospital in 1952. Having served as chief dietitian of Sinai Hospital, Baltimore, for three years, and at Torrance State Hospital, Torrance, Pa., and Armstrong County Hospital, Kittanning, Pa., Miss Hartman has gained practical experience in hospital food service operations.



for a **balanced program of parenteral nutrition...**

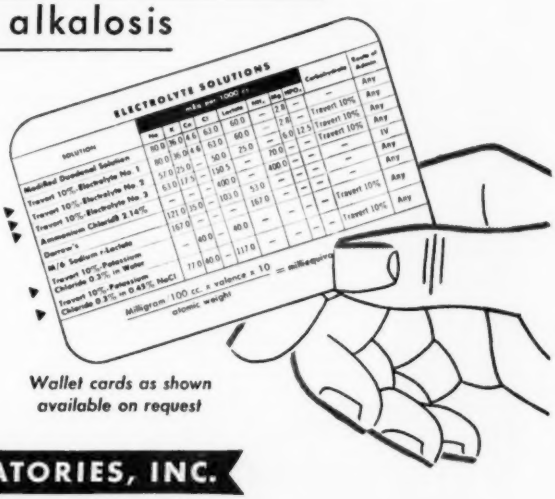
5 NEW

Travert® 10%-Electrolyte

SOLUTIONS

all the advantages of Travert* *plus* replacement of electrolytes, and correction of acidosis and alkalosis

* ***Travert*** 10% Solutions provide:
twice as many calories as 5% dextrose,
in equal infusion time,
with no increase in fluid volume;
a greater protein-sparing action as
compared to dextrose;
maintenance of hepatic function.



Wallet cards as shown available on request

products of

BAXTER LABORATORIES, INC.

Morton Grove, Illinois • Cleveland, Mississippi

DISTRIBUTED AND AVAILABLE ONLY IN THE 37 STATES EAST OF THE ROCKIES (except in the city of El Paso, Texas) THROUGH

AMERICAN HOSPITAL SUPPLY CORPORATION

GENERAL OFFICES • EVANSTON, ILLINOIS

Roving Reporter

London's Latest

The first important hospital building to be completed in London since the end of World War II contains the first machine of its kind to be built for x-ray therapy, an application of war-time discoveries to medicine. It is an 8,000,000 volt linear accelerator for accelerating atomic particles to high speeds, incorporating in one machine all the facilities needed to permit the full technical advantages to be gained by using very high energy radiations.

Making possible the delivery of an adequate dose of highly penetrating 8,000,000 volt x-rays to a deep-seated tumor, the machine has been designed by Britain's Atomic Energy Research Establishment, the radiotherapeutic research unit of Britain's Medical Research Council, and Metropolitan-Vickers Electrical Co., Ltd., in close collaboration. It is housed at the south end of the new building erected for the Medical Research Council at Hammersmith Hospital, London.

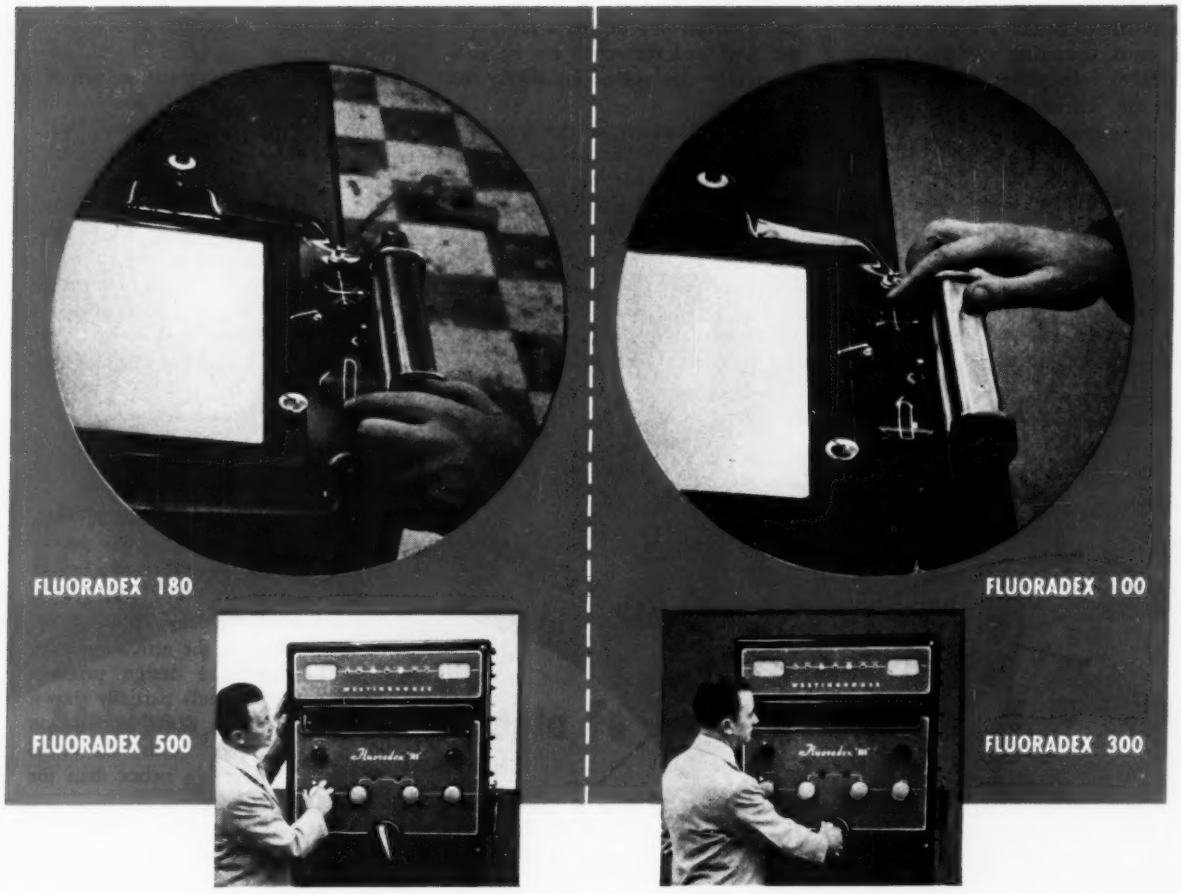
At the north end of the building, a 45 inch cyclotron is under construction for medical use. In this machine heavier atomic particles are made to travel at speeds in the region of 30,000 miles per second and give rise to very penetrating radiation. To prevent the escape of this radiation, the machine, which weighs 180 tons, is housed in a large concrete room with ceiling and walls from 6 feet to 10 feet thick, and sealed in by two close-fitting sliding concrete doors weighing 35 and 190 tons. The whole installation is operated from a remote control room.

MAKING ISOTOPES AVAILABLE

Cyclotrons produce the radioactive materials known as radio-isotopes which have a variety of medical applications in both diagnosis and therapy, and the importance of this cyclotron is its ability to produce, at a hospital, certain isotopes which have a very short life—in some cases a matter of a few minutes only—and which must be used immediately they are produced.

The linear accelerator treatment room is surrounded by concrete walls 4 feet to 6 feet thick. The protection to the staff is greater than is necessary for its safety and sufficient to prevent interference with work being carried out in adjacent research laboratories involving the measurement of minute quantities of radioactive material. There is easy access to the treatment room, and the operator can view the patient by means of a periscope system.

The name of the machine derives from the fact that it consists of a specially designed straight copper tube 10 feet in length, along which a beam of electrons is accelerated by very high frequency radio-waves. The use of such radio-waves has been made possible by the war-time development of microwave valves, such as the magnetron, and of other technics used in radar. The electron beam strikes a gold target, and x-rays are produced. These are highly penetrating, since they are generated by electrons with an equivalent voltage of 8,000,000, the magnitude of which may be judged from the fact that the voltage used in conventional deep x-ray therapy equip-



Room-to-Room Uniformity with the Westinghouse Twins

In answer to doctors' problems of equipment complexity, Westinghouse introduces the Westinghouse twin tables and twin controls. The Fluoradex 180 and the Fluoradex 100 are identical in every detail except that one tilts through 180° while the other offers up to 10° Trendelenburg tilt. The Fluoradex 500 and the Fluoradex 300 offer identical controls except that one is rated at 500 MA, the other at 300 MA.

These twin tables and controls can be placed in adjoining rooms, and they relieve the radiologist of equipment consciousness as he moves from room to room. The technician, too, is relieved of the necessity of handling totally different types of controls. Departmental efficiency is increased markedly by this room-to-room uniformity.

Check with your Westinghouse X-ray representative, or write to Westinghouse X-ray Division, Dept. E-92, at the address below.

X-RAY DIVISION · WESTINGHOUSE ELECTRIC CORPORATION · BALTIMORE 3, MARYLAND

FLUOREX
PORTABLE UNITS
X-ACTRON
WESTLINE CABINETS
MONOFLEX
PFX
FLUORADEX
DUOCONDEX
SERVICE
ACCESSORIES

YOU CAN BE SURE...IF IT'S

Westinghouse

-08292

ment is 200,000, though there are in routine use in Britain a few x-ray therapy units operating at 1,000,000 or 2,000,000 volts. Two million volts is also the effective voltage of the recently introduced cobalt 60 teletherapy unit.

TREATMENT TIME SHORTENED

The linear accelerator x-ray beam can be directed accurately into the patient at any desired angle. The patient is positioned in the x-ray beam by moving the floor of the treatment room up and down, and by using a specially designed moving couch. The three movements of the x-ray beam, the floor, and the couch can be automatically controlled by electronic equipment.

The high tensity of the beam that is directed into the patient shortens the time of each treatment to about two minutes, and the extremely penetrating nature of the x-rays allows the delivery of a high dose to the tumor without damage to the skin.

A true assessment of the value of this form of therapy may not be made for a long time, but one certain advantage, the Medical Research Council claims, is that the absence of any skin reaction makes it possible to treat patients with a much greater degree of comfort than was formerly possible. In addition, a much larger number of patients can receive treatments in a given time.

Extensions of the principles used in the 8,000,000 volt linear accelerator have made possible the design of a compact 4,000,000 volt machine suitable for use in routine radio therapy departments, orders for which have been placed by Britain's Ministry of Health.—PHYLLIS DAVIES, *feature writer, formerly on the staff of the London Daily Mail.*

We Are Indebted to—

Donor recognition has changed with fashions in interior design, and the old bronze wall plaques are out of place in modern lobbies.

Children's Orthopedic Hospital, Seattle, described in the article on page 63, has solved the design problem handsomely, as is only partially shown in the photograph which appears on page 10. In other words, the actual effect is considerably richer than the picture indicates.

What appears to be a wall paneled with squares of walnut is actually the easier-to-maintain laminated plastic with a walnut stain. On alternate panels are strips of polished brass, bearing the names of donors. The brass strips are of uniform size, and each represents a gift of $300 or more to the new hospital building.

On the wall to the north of the information desk above a planter box filled with showy plants are 33 panels, 11 on the length of the wall and three deep. Each panel measures 25 by 20 inches.

The list of donors makes good reading, as the new trend in giving is quickly demonstrated. Business firms, industries and labor unions seem to dominate the wall, although, of course, many individual donors are found, too. Boeing Airplane Co., Joint Council of Teamsters No. 28, Tide Water Associated, Northwest Airlines and Employes, B.P.O.E. No. 1482, Kenworth Motors—these are some of the names that leap out at the visitor.

What has happened to the donors of wings, rooms and equipment in the old hospital? Have they been forgotten? Not at all. Along the walls of the Memorial Stairway leading to the second floor, the plaques from the old

Above, operator easily slides load from stainless steel Troy "Slyde-Out" washer.

Above. Troy 6-roll Flatwork Ironer finishes about 16,000 lbs. of linens per 40-hr. work week at Santa Fe Hospital laundry. Below: Weekly pressing requirements include 150 doctors' coats, 400 nurses' uniforms and work clothes for hospital employees.

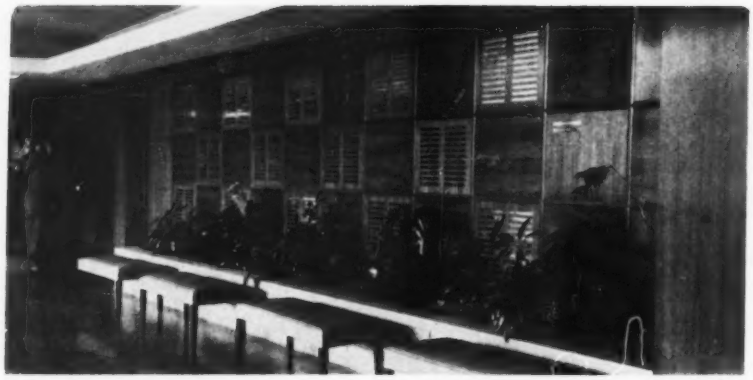
Atchison, Topeka and Santa Fe Hospital Chooses *"Slyde-Out"* Washers

Planning a new laundry for the Atchison, Topeka and Santa Fe Hospital in Topeka, Kansas, Hospital Administrator Fred Walters and Laundry Superintendent Morris Roudybush made a thorough study of available laundry machinery, finally decided they'd get more for their money by installing Troy equipment including "Slyde-Out" washers. They are well satisfied with their choice, because "Slyde-Out" washers can be unloaded as quickly and easily as mechanical dump machines, yet "Slyde-Outs" cost a lot less. "Slyde-Outs" are available with fully automatic, semi-automatic and manual controls.

If *you're* interested in greater laundry efficiency at reasonable cost, investigate "Slyde-Out" Washers and the complete line of Troy laundry equipment for large and small hospitals. Ask your Troy representative or write our factory for free illustrated catalogs.

Troy LAUNDRY MACHINERY

Division of American Machine and Metals, Inc.
EAST MOLINE, ILLINOIS



The north wall of the main lobby of Children's Orthopedic Hospital is used to display brass strips listing the names of generous donors. What appear to be walnut panels are actually laminated plastic.

building have been reinstalled, clearly illustrating the hospital's determination that each contribution, past as well as present and future, is worthy of lasting recognition.

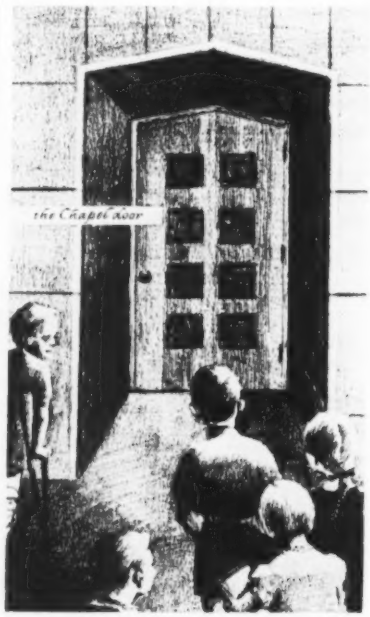
Free Moving

Seattle largely laid aside its routine tasks on the spring Saturday that Children's Orthopedic Hospital moved to its new building.

The scene at the old hospital on Queen Anne Hill took on a gala spirit as small patients, dressed in gay prints or spic and span jeans, were placed into waiting taxicabs made available by a local cab company. The sicker children—some in traction, tiny babies in isolation cribs, and even a child or two in oxygen tents—were carried to ambulances provided by a local ambulance service. The cab company had supplied 700 multicolored balloons, which were used to decorate the cabs and to amuse the youngsters on their trip to the new building.

As the children were taken out one door, hundreds of volunteers, members of the Teamsters' Joint Council No. 28, followed one another out a larger door laden with beds, wheel chairs, and other pieces of furniture. Huge vans, donated by the Truck Owners' Association and decorated with "Operation Orthopedic" banners, were soon loaded and, amid the grinding of TV cameras and newsreels and the flashing of photographers' bulbs, started off on a parade-like journey to the new hospital.

A Seattle catering service saved the hospital a large sum of money by providing hundreds of free sandwiches and coffee to the volunteers.



Postcard showing the entrance to the beautiful chapel of Children's Orthopedic Hospital in Seattle.

For Friends and Collectors

Every visitor wants a picture postcard of the new Children's Orthopedic Hospital, and two of these have been issued to date. One is an aerial view of the pink brick and blue aluminum building and the second, shown here, is a sketch of the chapel door. The bronze plaques on the door were designed by Jean Johanson and they tell the story of the creation. The chapel, which is interdenominational, has been decorated to appeal to children.

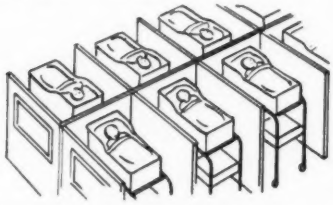
(Continued on Page 12)

New 2-Way BASSINET

1. FOR ROOMING-IN TECHNIQUE
   or
2. FOR CUBICLE ARRANGEMENT IN NURSERY

ROOMING-IN TECHNIQUE

The bassinet is wheeled from the nursery to the mother's room. The entire unit is light in weight and moves easily on rubber-tired swivel casters. Extra-long extension base slides under bed, brings basket and supplies within easy reach for mother to work on infant.



CUBICLE TECHNIQUE IN NURSERY

Self-contained bassinet holds all necessary equipment for individual attention. Basket, utensil holder and shelf are conveniently accessible. Light weight and simplicity of design aid flexibility of arrangement. Unit takes up minimum amount of space, gives nurse ample working area.

REMOVABLE PLASTIC BASKET — Light weight and sanitary. All corners and edges are rounded. Basket can be tilted at either end. Has name-card holder.

UTENSIL HOLDER is portable and can be attached to either side of stand within easy reach of mother or nurse. Metal containers hold cotton balls, oils, swabs, and other supplies.

SHIELDED SHELF holds linens, diapers, blankets, etc. Welded to stainless steel tubular uprights. Inside corners rounded to facilitate cleaning.

EXTRA-LONG EXTENSION BASE — designed to slide under bed. Brings basket and accessories within easy reach for mother to work on infant.

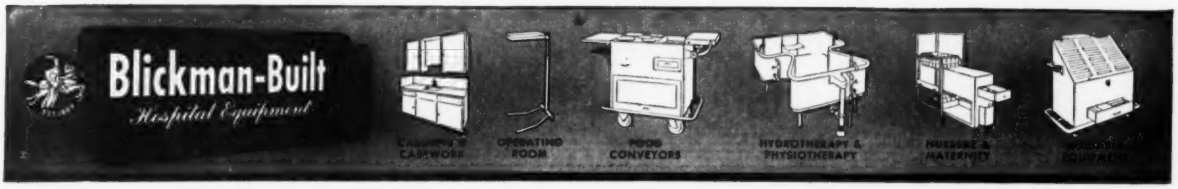
BOYLSTON Model STAINLESS STEEL BASSINET with Plastic Basket

• Whether your institution employs rooming-in technique or cubicle nursery arrangement, this low-cost stainless steel bassinet serves either with utmost safety and facility. All necessary supplies are within convenient reach of nurse or mother. Simple in design, of sturdy, welded construction, the bassinet is easily cleaned and sterilized. There are no painted surfaces to chip or crack, no dirt-collecting joints or crevices. Here is a Blickman-Built unit priced to meet your budgetary requirements — yet so durable that it virtually eliminates maintenance or repair costs. Write for further information.

SEND FOR OUR CATALOG 11-NEC

• Illustrates and describes many other units of Blickman-Built equipment for nursery and pediatric departments, as well as for milk formula rooms.

S. Blickman, Inc., 1501 Gregory Avenue, Weehawken, N. J. New England Branch: 807 Park Sq. Bldg., Boston 16, Mass.



Beryllium Study at M.G.H.

The Atomic Energy Commission has given Massachusetts General Hospital the funds to operate a Beryllium Case Registry. Exposure to beryllium compounds on the part of industrial and research workers has created a man-made disease that has been reported in the medical literature for the last 10 years.

The registry will have facilities and funds for the prompt handling of any case records, x-ray films or tissue submitted by practicing physicians, roentgenologists and pathologists.

Dr. Harriet L. Hardy, who is associated with the registry at M.G.H., says its purposes are: (1) to make possible a study of the epidemiology of this disease; (2) to evaluate the beryllium hazard of incriminated operations, and (3) to disseminate knowledge of the clinical course of beryllium poisoning, especially in relationship to its medical management. Cases will be entered into the registry anonymously, and from time to time data will be sent to participating physicians, summarizing facts that have been established.

Generous With Sick Leave

Passavant Hospital, Chicago, has loosened up on sick leave. It believes itself to be the only hospital that permits an employe to take paid sick leave without having to work at least six months to earn that privilege.

Under Passavant's new policy, an employe accumulates sick leave at the rate of one day for each complete calendar month of service up to 12 days. Sick leave is now computed from the employe's service anniversary year rather than from the first of the calendar year.

For Realistic Living

Smith Pavilion is a Chicago penthouse that goes in for "activity therapy." Its wide windows give a feeling of freedom and optimism.

The pavilion is on the roof of Smith Building, the psychiatric unit of St. Luke's Hospital. In the clublike pavilion, the psychiatric patient is in an environment that "avoids hospital atmosphere" and that provides, under controlled conditions, some of the elements of realistic living that for a particular patient at a particular time are therapeutic for him.

The south end of the pavilion is a sitting room equipped with radio and TV sets and furnished with lounge chairs and comfortable couches for rest, reading and relaxation.

The center area is used for group activities: active games, card parties, folk and square dancing, dramatics, and group dining. A partially partitioned area there is for arts and crafts, and four registered occupational therapists operate on a shift basis from 9:30 a.m. to 9:30 p.m. seven days a week.

Not all the guests at the penthouse are hospital patients. With this facility, the psychiatrist can prescribe activity therapy for his patients who are emotionally ill but who are better and more economically treated while living at home.

Interpersonal relationships between doctors, nurses, therapists and their patient are important to the therapeutic response of the patient, St. Luke's psychiatrists maintain, and Smith Pavilion gives the psychiatric unit a chance to develop a distinctive therapeutic tone, which is "a composite of all the therapeutically appropriate attitudes of the attending personnel and the attitudes of recovering patients."

for proved economies

"every plunger fits every barrel"

B-D MULTIFIT® *Syringes*

You can cut syringe costs at least 40% with B-D MULTIFIT Syringes. In one recent study of five hospitals with a combined bed capacity of 1774 patients, use of B-D MULTIFIT Syringes reduced syringe costs an average of 55%!

HERE'S HOW B-D **MULTIFIT** SYRINGES MAKE SUCH SAVINGS POSSIBLE:

Lower RATE of Replacement
—the clear glass barrel virtually eliminates loss from friction and erosion.

Lower COST of Replacement
—in case of breakage, you lose only the broken part—the unbroken part remains in use.

B-D MULTIFIT Syringes provide *time* savings, too—ease and speed of assembly cut handling time, free personnel for other tasks.

BECTON, DICKINSON AND COMPANY • RUTHERFORD, N. J.

B-D AND MULTIFIT, T. M. REG. U. S. PAT. OFF.

A packaged "TIME and LABOR SAVER"
for O. R. PERSONNEL

RACK-PACK ™

the New Method of Packing

B-P RIB-BACK SURGICAL BLADES

This "eye-view" tells you the story . . . "from RACK-PACK to jar *in a matter of seconds.*"

Its real Time and Labor saving features are there to be seen.

REMOVE COVER

Contains one gross of one size blades, on 4 RACKS.

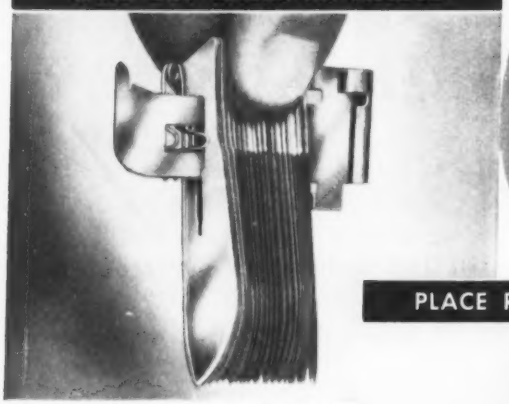
NO unwrapping of individual blades.

NO removing of individual blades.

NO handling or racking of individual blades.

. . . already on RACK—ready for sterilization by *any* established method.

TAKE OUT RACKS AS NEEDED



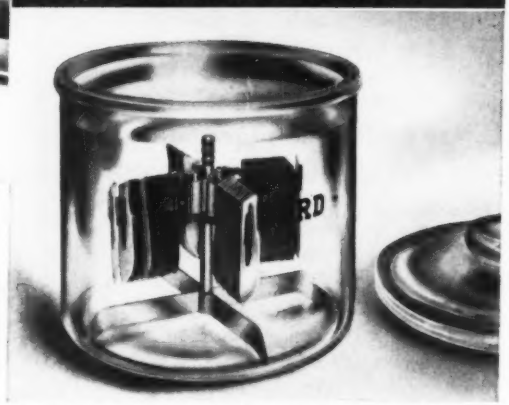
RACK with 36 blades ready to be placed on RACK-PACK STAND.

All RACKS fit the RACK-PACK STAND. *Note* — Notch at end makes removing of one or more blades a simple and easy matter.

PLACE RACKS ON STAND

It's Sharp

IMMERSE STAND IN GERMICIDAL SOLUTION



B-P Blade Jar with loaded RACK-PACK STAND immersed in germicidal solution ready for use in O.R.

Need we say more? The RACK-PACK is as reliable a Time and Labor saver for O.R. Personnel as B-P RIB-BACK Blades are in giving maximum cutting efficiency. *TRY IT!*

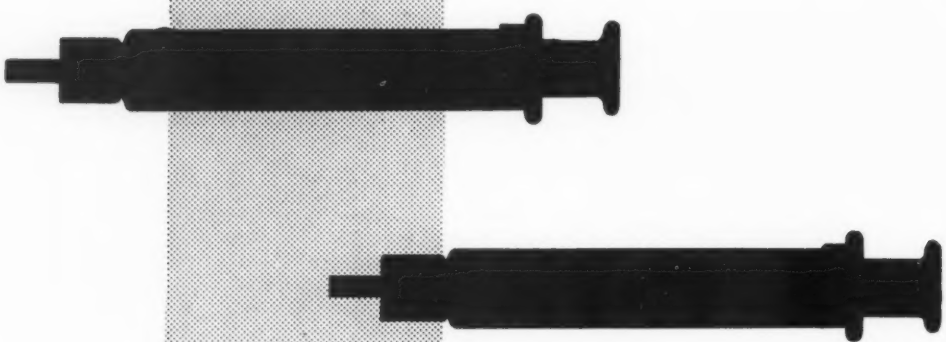
Order from your dealer.

BARD-PARKER COMPANY, INC.
Danbury, Connecticut, U.S.A.

THERE'S "DOLLARS" AND "SENSE" REASONING IN THE USE OF B-P RIB-BACK BLADES

Which of These

QUALITY SYRINGES SAVES YOU FROM 10% TO 30%?



Bishop Blue Label syringes, of course!

Yes, the biggest syringe bargain is Bishop Blue Label syringes.

Bishop Blue Label syringes give you identical quality and performance with any other premium quality non-interchangeable syringe . . . yet Blue Label syringes save you from 10% to 30% over other quality syringes. And like all high quality syringes each Blue Label syringe has years of engineering experience and product integrity built into it.

Blue Label syringes are precision crafted to meet and exceed Federal specifications; have longer lasting ground glass surfaces with permanently tired markings; triple plated hubs; stainless steel piston brakes, and Bishop's exclusive SEALON-TIP CONSTRUCTION . . . your assurance of complete freedom from contamination between the glass end and the metal tip.

No matter what high quality non-interchangeable syringe you now use, you'll be glad that you tried Bishop Blue Label syringes, because you can't buy better than Bishop Blue Label syringes.

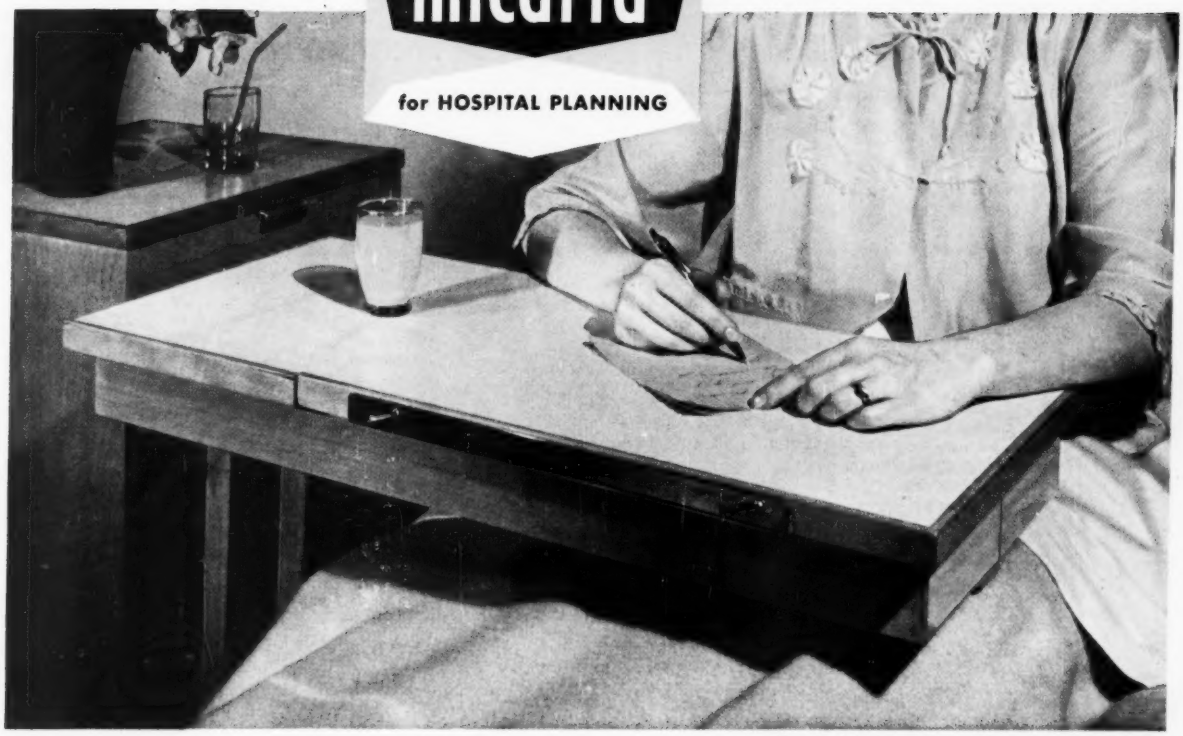
Buy Bishop and save from 10% to 30% over other premium quality syringes.

Order from your dealer, or write direct.

J. BISHOP & CO. • *Platinum Works*
Medical Products Division • Malvern, Penna.

This is Westinghouse micarta®

for HOSPITAL PLANNING



Over-bed Table and Cabinet by Hospital Furniture Inc.

Resists food and medicine stains . . . cuts replacement and refinishing costs

MICARTA® is the long-run, low-cost solution to hospital problems where tables, counters and other functional surfaces must withstand the rigors of constant use. The tough plastic surface of this efficient and decorative material provides a remarkable resistance to the bugbears of hospital maintenance—stains, burns, scars or dents.

MICARTA is available in a wide variety of colors, patterns and woodgrains. Specify MICARTA to your architect, builder or contractor—for either modernization or new building.

It will pay you now to investigate the possibilites of this hard-working, attractive material. MICARTA hospital furniture is obtainable, today. Fill out the coupon below for names of manufacturers and complete information.

J-06518

Westinghouse micarta®

distributed by | UNITED STATES PLYWOOD CORPORATION
largest plywood organization in the world
and U.S.-MENGEL PLYWOODS, INC.

UNITED STATES PLYWOOD CORPORATION
55 West 44th Street, New York 36, N. Y.
Please send full information on MICARTA and its applications.

NAME_____

ADDRESS_____

CITY_____ ZONE__ STATE_____

MH-1-54

Here's inside information on the finest Ice making unit ever made

STANDARD 2000 LB. CAPACITY UNIT

CYLINDER TUBE-ICE CRUSHED TUBE-ICE

OPERATION OF THE MACHINE

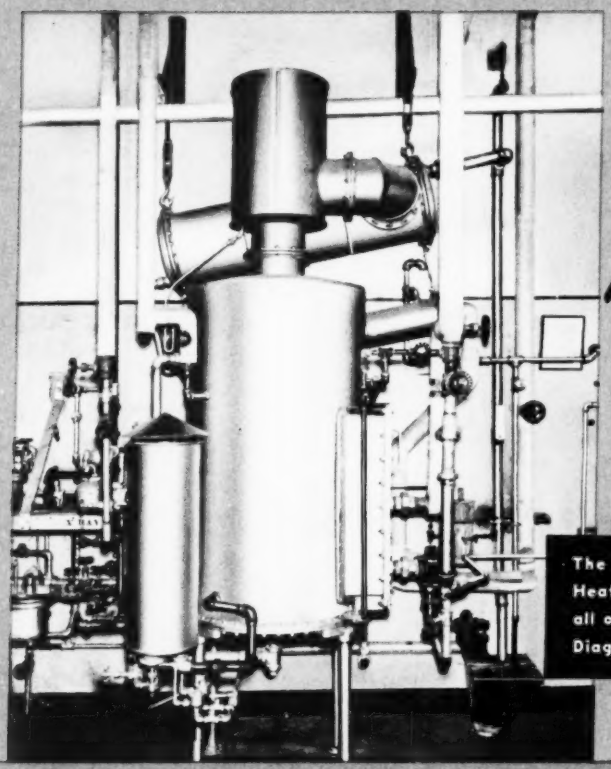
1. Single toggle switch controls starting and stopping of unit. Ice discharges through base of freezer to patented ice sizing cutter.
2. A three-position selector switch provides automatic control of ice making unit to produce and store cylinder and crushed Tube-Ice consecutively (requiring two ice bin thermostats) or either type of ice exclusively.
3. Automatic blowdown in water pan maintains freshness and aids in reduction of concentrated solids.
4. An upper "scoop out" for small quantities of ice and a lower "shovel out" door are provided in storage bin.
5. Minimum of 3" Fiberglass insulation between storage bin walls. Bin has removable partition if but one type of ice is desired.
6. Copper or brass tubes used for freezer, condenser and refrigerant piping.
7. Tube-Ice Units are completely self-contained and conform to A.S.M.E. Code. Require only the addition of the refrigerant charge, and water and electrical connections.

WRITE FOR BULLETIN

HENRY VOGT MACHINE CO.
Louisville 10, Ky.

BRANCH OFFICES: New York, Philadelphia, Chicago, Cleveland, St. Louis, Dallas, Charleston, W. Va.

How the World's Best-Known Hospitals *put* BARNSTEAD *pyrogen-free* WATER *to work*



The Mayo Clinic's SS-50 Steam-Heated Water Still, which supplies all of the distilled water used in the Diagnostic Clinic and Laboratory.

LIKE HUNDREDS of hospitals the world over, the Mayo Clinic, of Rochester, Minn., depends on Barnstead Pure Water Equipment for pyrogen-free water of the highest purity.

A Barnstead SS-50 Steam-Heated Water Still, located in the Diagnostic Clinic and Laboratory Building, feeds a large storage tank atop the building. This single-distilled water is then carried by a distribution system to the various laboratories, where much of it is used for washing and cleaning purposes.

The remainder of the single-distilled water is piped to other Barnstead Water Stills in the building, which produce a double-distilled effluent of extreme purity for use in the most exacting scientific experiments and the compounding of intravenous solutions.

The Mayo Clinic relies on Barnstead for *Quality-controlled* purity which never varies — the result of 75 years' specialized experience in water still design. Write to Barnstead today for our Pure-Water Engineers' recommendations on *your* distilled water problem — and your free copy of Bulletin 116, which describes the entire Barnstead Hospital line.

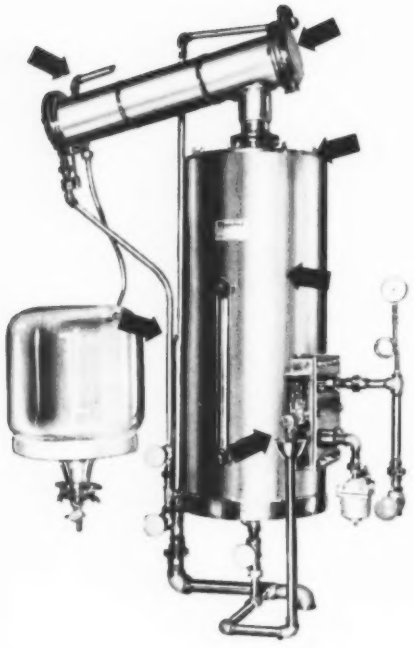
OVER 200 DIFFERENT STYLES AND SIZES

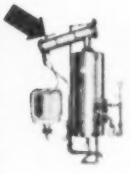
Barnstead STILL & STERILIZER CO.

A Still for Every Hospital — For Every Distilled Water Requirement

50% Greater Supply of *distilled water*

with the NEW BARNSTEAD "15" HOSPITAL STILL





BARNSTEAD Vented Condenser

Counter current, horizontal condenser effectively separates and expels gaseous impurities. One of the reasons why Barnstead distilled water is always pure — always pyrogen-free.

BARNSTEAD Constant Level Control

Constant Level Control has open hot well to expel gases from the preheated feed water — thus eliminating most of the volatile impurities at the outset.

BARNSTEAD Still Easy to Clean

Heating coil mounted on removable plate on side of evaporator. Easily accessible for cleaning. Under average water conditions Barnstead Stills stay in service for months between cleanings.

BARNSTEAD Spanish Prison Baffle

A Barnstead exclusive. It scrubs the vapors to trap and strip out pyrogens. It is a must with hospitals, blood banks, and pharmaceutical manufacturers.

BARNSTEAD Evaporator

Wide and deep, designed for low vapor velocity. Ample steam disengaging space above water level so that vapors rise slowly and lazily. 36" vapor rise for water to condenser entrance. Prevents entrainment at the outset.

BARNSTEAD Constant Bleeder Device

The Barnstead Constant Bleeder Device continuously deconcentrates water in evaporator to retard scale formation and prevent foaming or priming.

Barnstead STILL & STERILIZER CO.

First in Pure Water since 1878

27 Lanesville Terrace, Forest Hills, Boston 31, Mass.

The entire Carrom story is contained under one cover . . . providing fast, easy reference.

Each Carrom Furniture Grouping is separately catalogued and illustrated . . . you can quickly refer to the items you want.

Here's the story—

OF BEAUTIFUL, DURABLE FURNITURE BY

Carrom

Send for your copy of this interesting, informative Carrom Furniture Catalog! It contains photographs and descriptions of all Carrom furniture groupings and individual pieces . . . full color reproductions of Carrom's seven distinctive finishes . . . complete information on why Carrom is the best buy for beauty and durability. Write today!

CARROM INDUSTRIES, INC.
Ludington, Michigan

This Carrom Finish Page (illustrated in the catalog in full color) shows the exact tones available for all Carrom furniture

PROGRESS REPORT

Maxitron 1000—
1000 kvp 3.0 ma.
Photo courtesy Presbyterian Hospital, Denver.

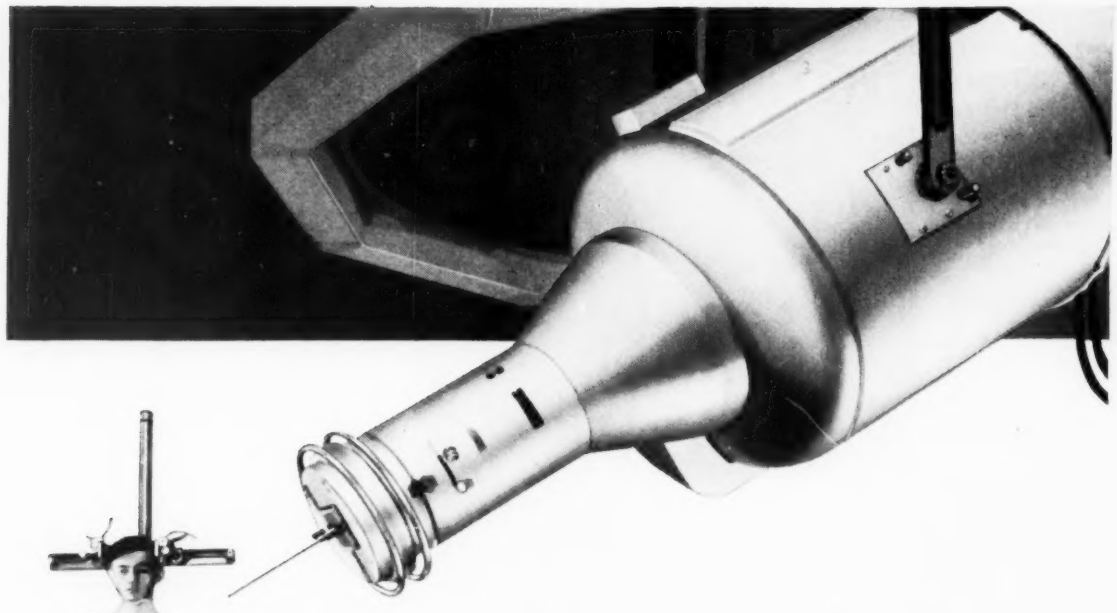
20 G-E Maxitrons—1 and 2 mev—now used for x-ray therapy... with four more awaiting installation

MEDICALLY proved . . . medically accepted — super-voltage radiotherapy is well past the trial stage. In addition to 24 Maxitron 1000s and 2000s for the medical profession, General Electric has installed 102 of these units, of the same basic design, in industrial plants all over the world. The oldest has been in service for 14 years. Another has been in almost daily use since 1943 and is *still using the original tube.*

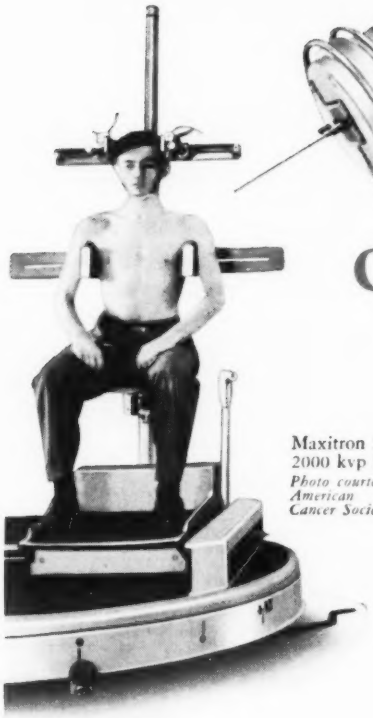
There's good reason for a record like this. General Electric tubes are *sealed off and permanently evacuated.* Their output is unvarying . . . with no daily maintenance required.

Remember, only super-voltage therapy allows you to combine increased depth dose, decreased volume dose and reduced skin reaction (see chart). At the same time, it assures uniform absorption in bone and soft tissue.

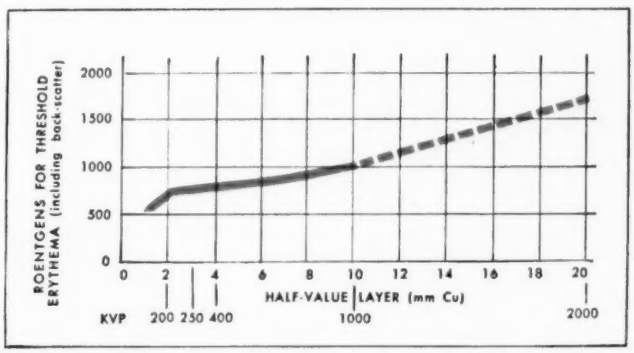
If you've been waiting until super-voltage x-ray proved itself, *wait no longer.* Get complete information on precise, dependable Maxitron 1000 and 2000 units from your G-E x-ray representative. Or write X-Ray Department, General Electric Company, Milwaukee 1, Wisconsin, Rm. H-12



on super-voltage therapy...



Maxitron 2000—
2000 kvp 1.5 ma.
Photo courtesy American Cancer Society.



Based on data taken from "Physical Foundations of Radiology," by Glazer, Quimby, Taylor & Weatherwax (Paul B. Hoeber, Inc.) extrapolated to 2000 kvp

» Like all G-E x-ray apparatus, these machines can be yours without initial capital investment on the Maxiservice® *rental* plan.

You can put your confidence in —

GENERAL ELECTRIC

Here's

the

BIG TRUTH*

about

boilers...

The only safe way to select boilers is on nominal capacity to operate at "cruising speed"...

KEWANEE

reserve plus rating

guarantees dependability, higher efficiency, lower costs, longer life—because it means "cruising speed" operation.

There's a lot of confusion in sizing boilers today because rating methods have not been brought into the open with a clear-cut definition. That's all changed with Kewanee Reserve Plus Rating. Here for the first time these truths are stated: Only nominal-rated boilers with built-in reserve *safely provide* efficiency—low maintenance—dependability—longer life. Only nominal-rated boilers *safely provide* for fluctuating loads—emergencies—expansion.

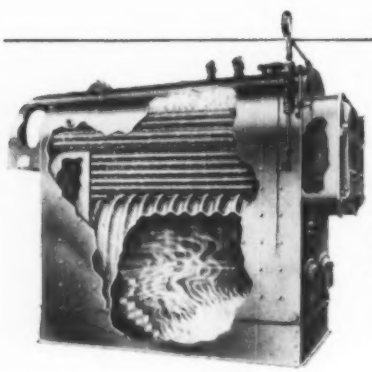
So when you consider "bidding data" be sure you compare like examples . . . know whether ratings are based on maximum capacity or nominal capacity.

Follow the Kewanee Reserve Plus Rating Plan which is based on the commercial code of the Steel Boiler Institute. Kewanee Reserve Plus certifies 50% or more extra power for pick-up and additional capacity. Kewanee gives you complete data and dimensions, so you can realistically consider sizing requirements.

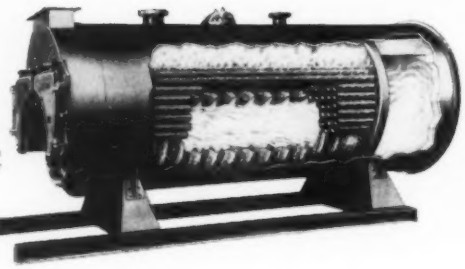
You can count on* KEWANEE *engineering

KEWANEE-ROSS CORPORATION • KEWANEE, ILLINOIS
Division of American Radiator & Standard Sanitary Corporation

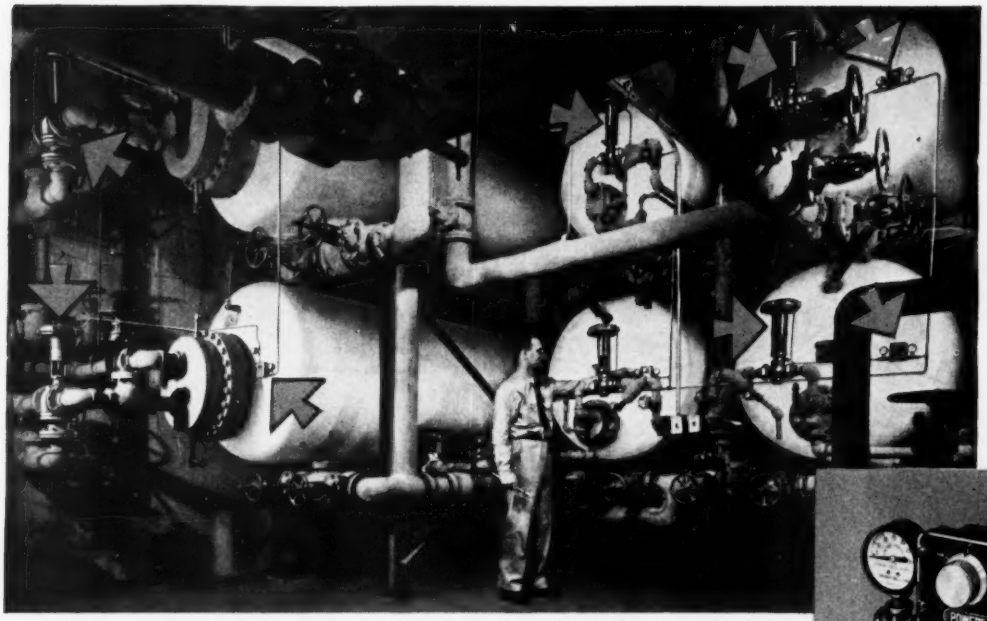
Serving home and industry • American-Standard • American Blower Church Seats & Wall Tile • Detroit Controls • Kewanee Boilers Ross Exchangers • Sunbeam Air Conditioners



Kewanee type "C" boiler
with exclusive corrugated crown sheet. 10 sizes for oil, gas or stoker 3650—42500 sq. ft. steam 5840—68000 sq. ft. water



M-800 series boiler
Here is rugged "M-800" Series Scotch Boiler constructed in 13 sizes for high pressure steam 30 to 304 horse power and low pressure 15 lb. steam or 15 lb. water.



Chief Engineer Edward MacDonald states "Performance of Powers Accritem Temperature Regulators has been highly satisfactory on the 6 water heaters shown above as well as on booster heater for dishwasher and for controlling cooling of condensate before discharge to sewer."

WATER HEATERS AT LEVER HOUSE New York City

Architects: Skidmore, Owings & Merrill

Consulting Engineers: Jaros, Baum & Bolles

Contractor: Gillman-Rous-Pesce Corp.

LUX

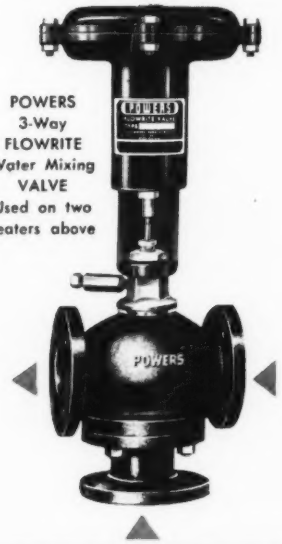
One of Lever Brothers Co. Famous Soaps

Powers ACCRITEM Regulator
Compressed Air or Water Operated

®POWERS WATER TEMPERATURE CONTROL

ACCkITEM Regulators were selected for LEVER BROTHERS beautiful modern building on Park Avenue in New York City. The air conditioning system here is also Powers controlled.

Water heaters in more and more prominent buildings are being equipped with Powers Accritem Regulators because of their —



POWERS 3-Way FLOWRITE Water Mixing VALVE Used on two heaters above

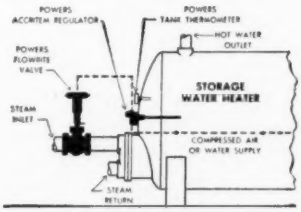
Important Features that Give Better Control and Lower Maintenance

- ***Adjustable Sensitivity*** and over-heat protection.
- ***Calibrated Dial*** temperature adjustment.
- ***Simple, Rugged Construction*** withstands vibration and insures years of reliable service.
- ***Temperature Ranges*** 50-250° F. and 150-350° F.
- ***Easy to Install.*** Requires 15 lb. supply of compressed air or water for its operation.
- ***Small Size***—regulator head is only 2⅞" x 3⅝", sensitive bulb is 12" long with ½" I. P. S. connection.

Bulletin 316 gives full details

Call Powers for aid with your problems of temperature control. Our more than 60 years of experience may be helpful to you. Whether you want a simple self-operated regulator or thermostatic water mixing valve or a pneumatic control system with recording controllers...contact Powers.

Unsurpassed for reliability and power to operate large or small diaphragm valves controlling Water Heaters, Heat Exchangers, Jacket Water Cooling for Diesel Engines or Air Compressors and many Industrial Processes.



POWERS Single Seat FLOWRITE VALVE Used on 4 heaters above

THE POWERS REGULATOR COMPANY

Skokie, Ill. • Offices in Over 50 Cities, See your phone book • Established 1891

(a91)

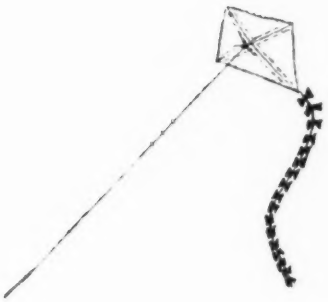
They all like

pediatric

ERYTHROCIN

TRADE MARK

STEARATE



(Erythromycin Stearate, Abbott)

oral suspension

. . . the cocci-killing antibiotic for children of all ages. Tasty, stable, ready for instant use. *No mixing required*—drug retains potency for at least 18 months.

Winter infections—otitis media, bronchitis, sinusitis, pharyngitis and pneumonia—are especially sensitive to *Pediatric* ERYTHROCIN. Also, pyoderma, erysipelas, certain cases of osteomyelitis, and other infectious conditions.

Many physicians make it a practice to always prescribe *Pediatric* ERYTHROCIN when the organism is staphylococcus, because of the high incidence of staphylococcic resistance to many other antibiotics. And when the organism is resistant or when the patient is sensitive to penicillin and other antibiotics.

Pediatric ERYTHROCIN is specific in action—*less likely to alter normal intestinal flora than most other antibiotics.* Gastrointestinal disturbances are rare. No serious side effects reported.

Pediatric ERYTHROCIN can be administered before, after or with meals. Available in 2-fluidounce, pour-lip bottles.
Your little patients will like *Pediatric* ERYTHROCIN. Abbott

DOSAGE

One 5-cc. teaspoonful
represents
100 mg. of ERYTHROCIN

25-lb. child • ½ teaspoonful
50-lb. child • 1 teaspoonful
100-lb. child • 2 teaspoonfuls
Every 4 to 6 hours

1. Kalistron dado. Maternity Ward, St. Vincent's Hosp., Bridgeport, Conn. Arch.: Fletcher Thompson.

Wall Center, U. S. A. — that's what they're calling United States Plywood Corporation. Among the wall coverings described below, you will find a solution to almost any wall problem — problems, for instance, like these:

Hospital walls that must resist bumps, scratches, chipping. **Rounded or curved walls** that call for wood panelling. **Hotel room walls** that should always look "fresh." **Fireplace walls** for "beauty on a budget."

Come to Wall Center, U. S. A. for new beauty treatments . . . new protection against wear. Read descriptions below—then send coupon.

Bring your wall problems to "WALL CENTER, U. S. A."

2. Kalitex on bedroom wall Hotel Roosevelt, N. Y. C.

3. Teak Flexwood law office of Miller & Burstein, Bridgeport, Conn. Architect: Victor Civkin.

4. Randomwood used in a home in Chappaqua, N. Y. Contractor: Joseph Cerrone.

1. Kalistron A transparent vinyl "coat of armor" shields this rich wall covering . . . its color is fused to the underside. Virtually impervious to scratches, scuffs, stains, roughhouse. A damp cloth cleans it. 33 colors. Ideal in hospitals, theatres, restaurants, schools — wherever traffic is heavy — and careless.

2. Kalitex Gives more protection than any other wall covering at anything like the price. Made much like Kalistron, with the same vinyl-protected beauty. Its rough textured pattern is distinctively different. Superb in hospitals, hotels, public buildings, etc.

3. Flexwood Genuine wood panelling in flexible form. Hence, you can curve it, wrap it around posts, get stunning matched grain effects over wide areas. Meets any fire code requirement. Over 25 million feet installed on new construction and alteration jobs. Every installation guaranteed. Widely used in banks, offices, public rooms, etc.

4. Randomwood Similar to Flexwood except the shading of the wood varies, giving an interesting "random" effect. Use it where imagination is high but budget is low. Hangs easily, like wallpaper. For a whole room or a dramatic single wall, in homes, small offices, anywhere. First cost is last cost for years.

Marketed Jointly by United States Plywood Corporation and The Mengel Company

UNITED STATES PLYWOOD CORPORATION
Dept. K80, 55 West 44th St., New York 36, N. Y.
(In Canada: Paul Collet & Co., Ltd., Montreal)

Please send information on products checked:

☐ Kalistron ☐ Flexwood
☐ Kalitex ☐ Randomwood

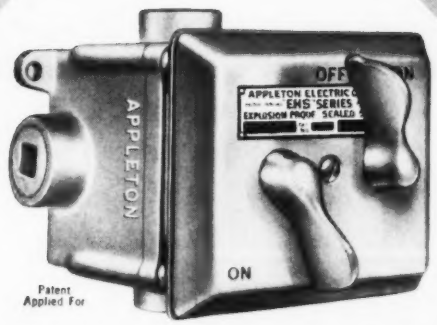
Name_____

Address_____

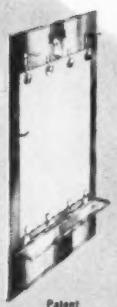
City_____ State_____

New, Versatile, Economical

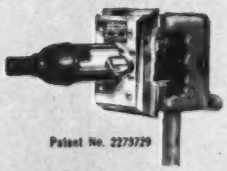
EXPLOSION-PROOF SWITCH by APPLETON



Type "EHS" Two Gang Switch
CLASS 1, Groups C and D



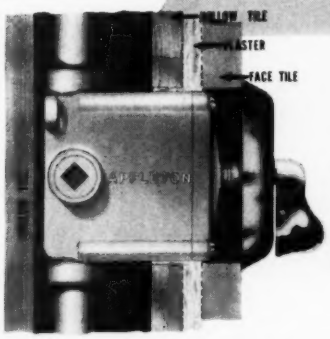
X-ray Film Illuminators for hazardous or non-hazardous locations.



Receptacle with Plug.

Two-gang Pilot Lights. Available in single gang and in combination with switch.

Portable Current Tap with Feed-in Plug.



featuring: **An Adjustable Cover offering a range from 9/16" Min. to 1-13/16" Max. to accommodate different wall thicknesses. Also includes a Self-Leveling Adjustment.**

Because of its adjustable cover feature, this "EHS" Series Explosion-Proof Switch is particularly suited to modernization programs. It is quickly and easily installed in walls of different plaster or tile thickness and will compensate for variations up to 5° off level.

"EHS" Series Sealed Switches are typical of *Appleton's* modern design and quality craftsmanship which characterize the entire line of *Appleton* explosion-proof hospital equipment.

Have you checked the hazardous areas in *your* hospital lately? Why not discuss with your architect or electrical contractor the urgent need for modern explosion-proof protection . . . *Appleton* protection!

Sold Through Electrical Wholesalers

APPLETON ELECTRIC COMPANY
1743 Wellington Avenue • Chicago 13, Illinois

APPLETON ELECTRIC PRODUCTS

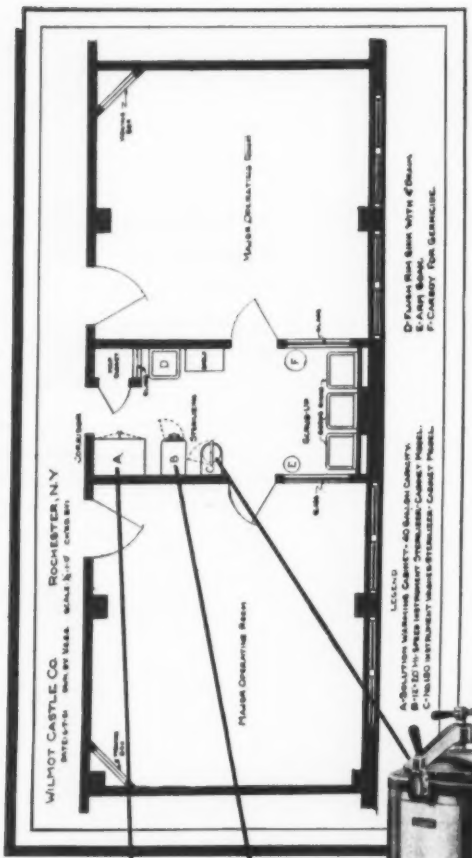
Also Manufacturers of:

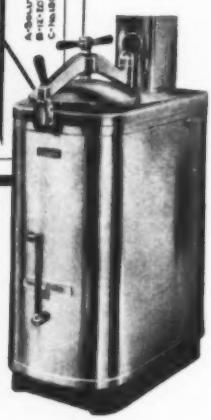
more in 'fifty-four'

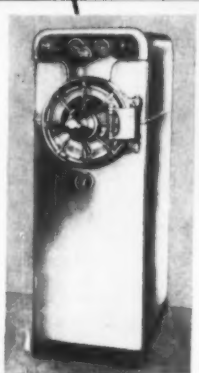
Year after year the demand for Wiltex and Wilco Curved Finger Latex Gloves has increased steadily—more Doctors have discovered their greater comfort, greater finger-tip sensitivity—more hospital buyers have relied on their longer-lasting properties to help reduce operating costs—more Surgical Supply Dealers have requested Wilson quality for their customers—this year will be no exception —there will be "more in fifty-four."

THE WORLD'S LARGEST EXCLUSIVE MANUFACTURERS OF RUBBER GLOVES

The Wilson
RUBBER COMPANY
CANTON · OHIO







Organization—

for greater O.R. efficiency

Castle SUB-STERILIZER ROOM PLANNING

in its advanced concept, now incorporates two important provisions that mean—

1. **unauthorized traffic being diverted from the surgery.**
2. **minimal sterilizing facilities, adequate for all routine and emergency needs.**

We at Castle believe that every hospital administrator, operating room supervisor and hospital architect will be vitally interested in this modern approach to sub-sterilizer room planning. Note the specimen blueprint of one of the world's most publicized institutions . . . Castle equipped!

STERILIZERS LIMITED TO ONLY 3 ESSENTIAL UNITS

● **Pressure Instrument Washer Sterilizer**

Washes instruments more thoroughly — faster. *Sterilizes* and *dries* instruments for immediate use or storage . . . all in a single operation within 10-12 minutes.

● **Hi-Speed Emergency Sterilizer**

For routine sterilization or fast emergency service as the name implies. Soiled or contaminated instrument can be made bacteriologically safe in 5 minutes.

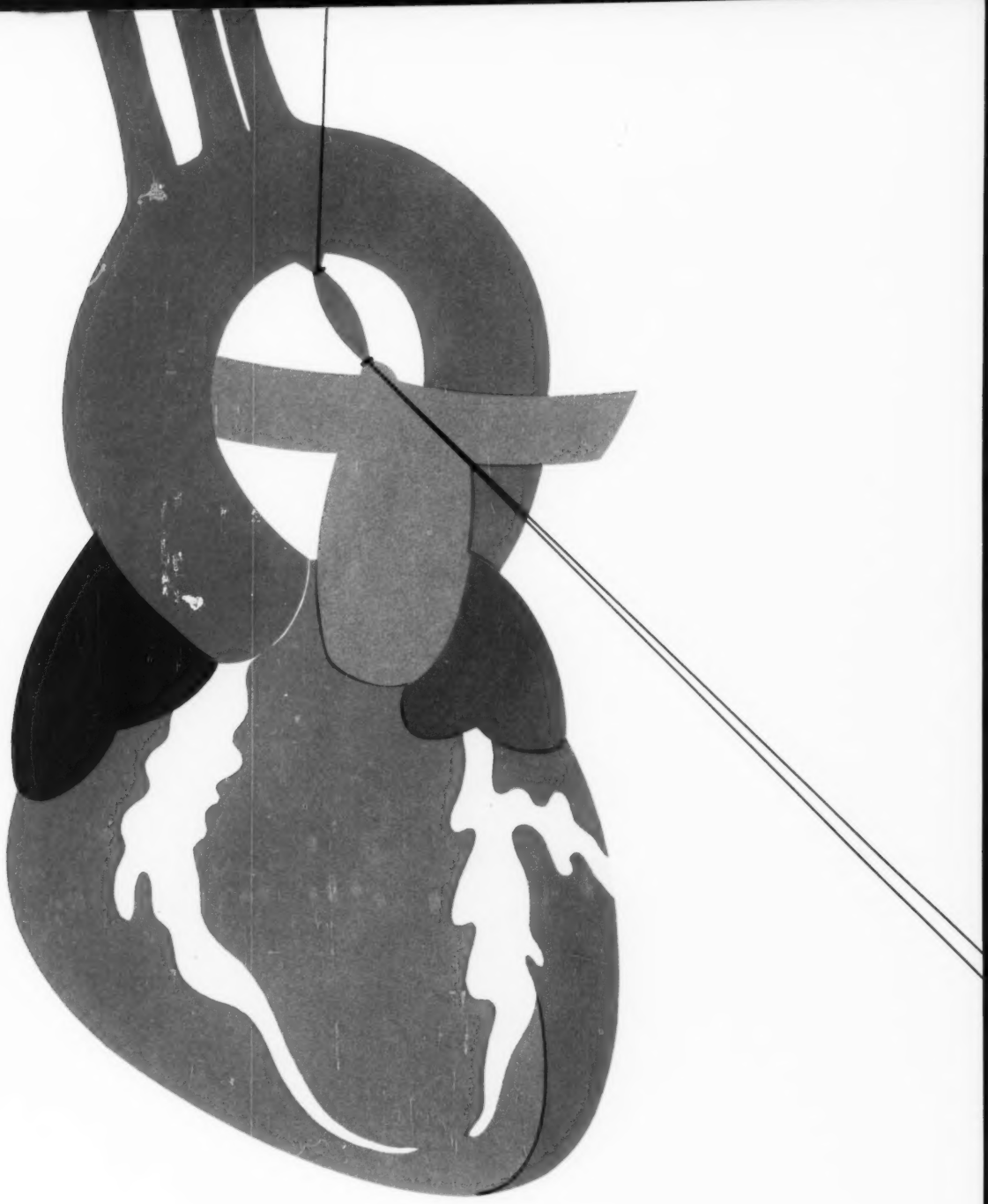
● **Warming Cabinet**

Precision built for temperature control of flasked sterile water, parenteral solutions, blankets and other supplies normally sterilized in the Central Sterile Supply.

WRITE TODAY for detailed information and benefit through our gratis Planning service

WILMOT CASTLE COMPANY
1175 University Ave. Rochester 7, N.Y.

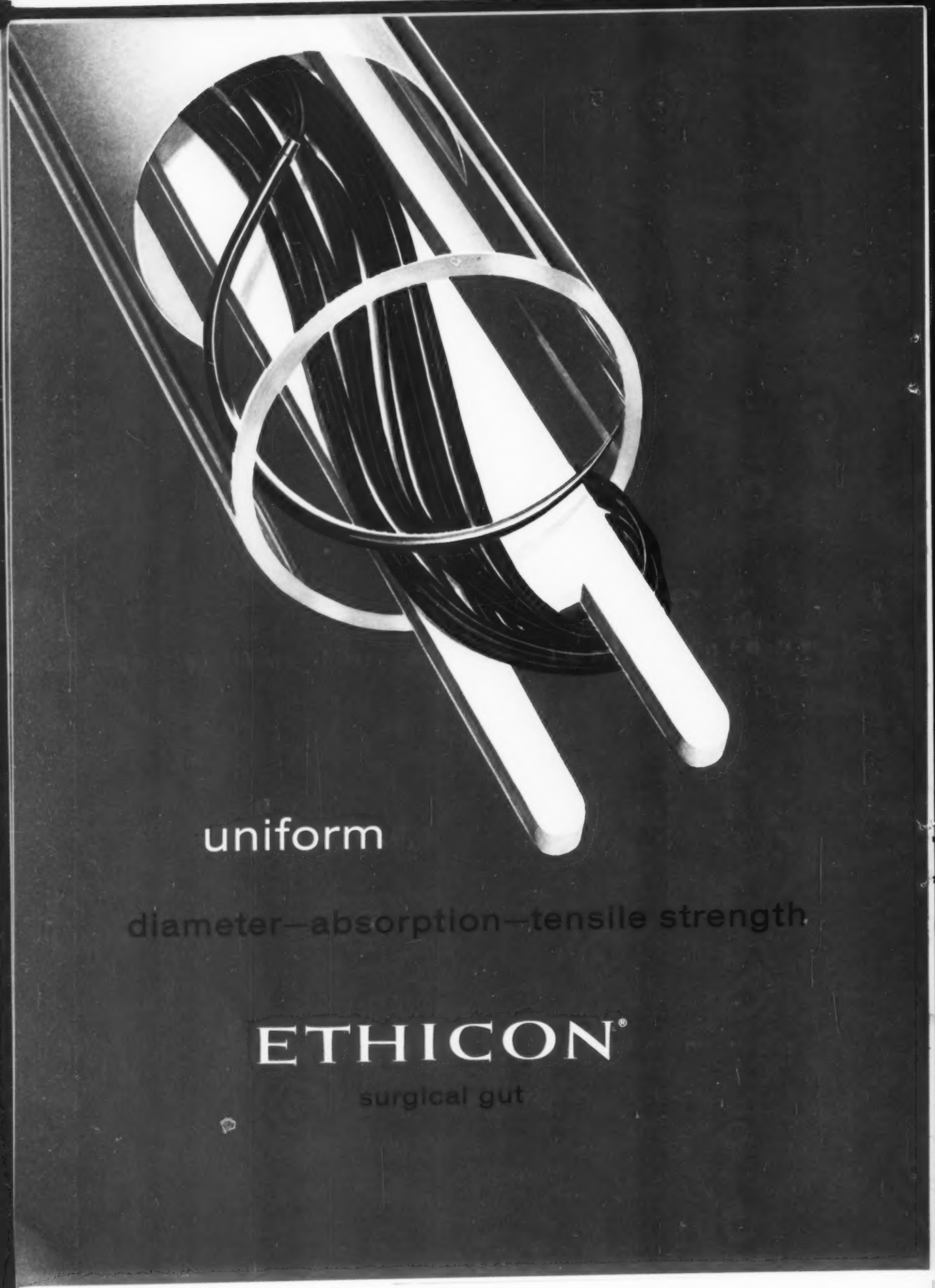
Castle STERILIZERS AND LIGHTS



setting new standards

ETHICON®

sutures


uniform
diameter—absorption—tensile strength
ETHICON®
surgical gut

WHAT WAS THE

BIG IDEA

For years, Neanderthal Junior worked off his excess energy by drawing cartoons on cave walls. Then one day, quite by accident, he had a big idea! Why not use the limb of a tree to pry a boulder over the edge of a cliff? The LEVER was a big idea.

You'll like McKesson's "Personalized Service"

More and more, busy hospital pharmacists are coming to depend on the conscientious, *personalized* service given by their McKesson & Robbins representative. Here are some of the benefits to you:

PERSONAL SERVICE . . . not only does the McKesson representative call on you at regular intervals, but a telephone call to the McKesson Division serving you will provide rush shipments in emergencies.

COMPLETE STOCKS . . . McKesson carries the most complete line of pharmaceuticals in the field.

FAST DELIVERY . . . there's a McKesson wholesale division and warehouse ideally located to serve you.

LESS DETAIL . . . when you order through McKesson, you have only *one* invoice, only *one* shipment to open and check, only *one* representative to see.

If a McKesson representative is not calling on you, or if you wish more information, write to McKESSON & ROBBINS, INCORPORATED, 155 E. 44th St., New York 17, N. Y.

McKESSON & ROBBINS

Incorporated

READY TO SERVE YOU

For fast delivery, with a minimum of detail and a maximum of service, get in touch with your nearest McKesson Division.

ALABAMA
Birmingham
Mobile

ARIZONA
Phoenix

ARKANSAS
Fort Smith
Little Rock

CALIFORNIA
Fresno
Los Angeles
North Hollywood
Oakland
Sacramento
San Diego
San Francisco

COLORADO
Denver

CONNECTICUT
New Haven

FLORIDA
Jacksonville
Miami
Orlando
Tampa

GEORGIA
Augusta
Columbus
Macon

ILLINOIS
Cairo
Chicago
Peoria
Rock Island

IOWA
Burlington
Cedar Rapids
Sioux City

KANSAS
Wichita

KENTUCKY
Louisville

LOUISIANA
New Orleans

MASSACHUSETTS
Boston
Springfield

MICHIGAN
Detroit

MINNESOTA
Minneapolis
St. Paul

MISSISSIPPI
W. Jackson

MISSOURI
Kansas City
St. Louis

MONTANA
Billings

NEBRASKA
Omaha

NEW JERSEY
Newark

NEW YORK
Albany
Brooklyn
Buffalo
New York City
Rochester
Syracuse
Yonkers

OHIO
Akron
Cincinnati
Cleveland

OKLAHOMA
Oklahoma City
Tulsa

OREGON
Portland

PENNSYLVANIA
Pittsburgh

RHODE ISLAND
Providence

SOUTH CAROLINA
Columbia

TENNESSEE
Chattanooga
Memphis
Nashville

TEXAS
Abilene
Amarillo
Dallas
El Paso
Houston
San Antonio

UTAH
Ogden

VIRGINIA
Roanoke

WASHINGTON
Seattle
Spokane

WEST VIRGINIA
Huntington

WISCONSIN
Milwaukee

HAWAII
Honolulu, T. H.

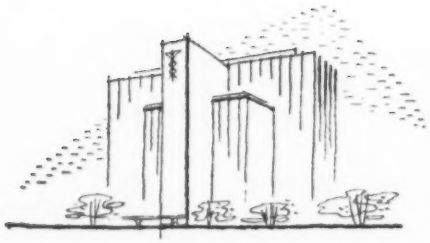
When it's a *Curity* Catgut Suture, the nurse just breaks the tube, removes the suture and hands it to the surgeon.

The work usually done to prepare sutures in the operating room *has already been done* in the *Curity* Laboratories. No dipping. No excess handling of a sterile product. No question about when the suture is properly pliable for surgery. Every *Curity* Suture comes from the tube in workable condition—just the way the surgeon wants it.

Ready-to-use *Curity* Sutures will save time and effort in *your* operating room. Plan now to make them part of your next surgical supply order.

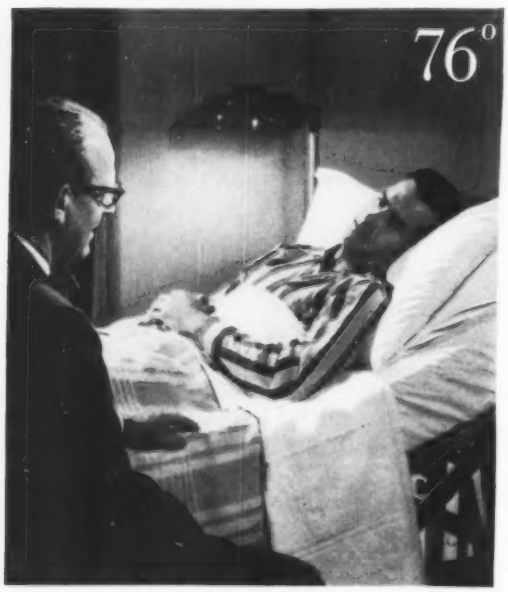
BAUER & BLACK

Division of The Kendall Company
309 W. Jackson Blvd., Chicago 6, Ill.



Modern hospitals aid patient recovery with a thermostat in every room

This patient in room 302 is well on her way to recovery after an accident, and her doctor prescribed a temperature of 70° which will be maintained with the Honeywell Hospital Thermostat in her room.



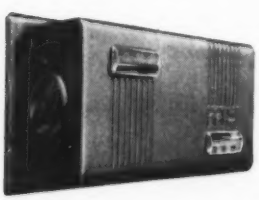
The patient in room 303 is recovering from surgery, however, and to help speed his recovery, his doctor prescribed a 76° room temperature—possible only with an Individual Room Thermostat.

EXACTLY prescribed temperatures in a patient's room can help the physician stimulate a speedy recovery . . . but this medical practice is possible *only with a thermostat in every room.*

No other method can compensate nearly so well for the varying effects of wind, sun, open windows, and other temperature factors in each room. That's the big reason why so many hospitals today install Honeywell Individual Room Temperature Control.

You'll want to investigate Individual Room Temperature Control if you plan to modernize your hospital or build a new one. Of course, the most economical time to install this system is when the hospital is being built . . . installations usually cost only between ½ and 1% of the expenditure per bed. And new installation methods make modernization economical, too.

For complete facts on Honeywell Controls for your hospital, call your local Honeywell office . . . or write Honeywell, Dept. MH-1-10, 351 East Ohio Street, Chicago 11, Illinois.



Mark of a modern hospital!

You get *all* these features *only* in this specially designed Honeywell Hospital Thermostat:

- ***"Nite-Glowing dials"*** permit inspection without disturbing patients.
- ***Magnified numerals*** make readings easy to see.
- ***New Speed-Set control knob*** is camouflaged against tampering.
- ***Air-operated:*** requires no special connections.
- ***Lint-Seal*** insures trouble-free, dependable operation.

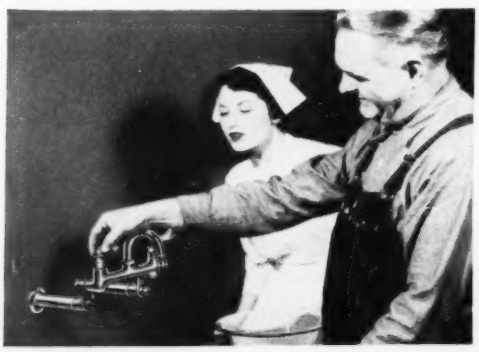
MINNEAPOLIS **Honeywell**

H HONEYWELL *First in Controls*

104 offices across the nation

CRANE HELPS YOU SAVE NURSEPOWER

Nothing wastes more time in a nurse's day than plumbing fixtures that are too few, too far away, too difficult to operate. The right Crane equipment in the right places can save hours of nursepower every day. Designed with the help of hospital experts, Crane hospital fixtures are specifically made to meet hospital requirements. In height, size, shape, and in types of water controls, each fixture is precisely planned to eliminate lost motion, save time, make work easier. It will pay you to get acquainted with the complete line of Crane hospital plumbing.



Less Maintenance! Crane Dial-ese faucet controls last longer—require less maintenance. That's because of the simple replaceable cartridge that contains all working parts. If necessary, old cartridge can be replaced with new one in seconds.

For nurses who have their hands full (and what nurse hasn't?)

Crane knee-operated valves leave *both* hands free for those countless daily tasks at sinks and lavatories.

Fitted with a combination hot and cold water control, this valve responds to the slightest touch of the knee . . . providing water that's all hot, all cold, or mixed exactly as wanted.

Promotes sanitation, too. No dirt or germs pass *from one* pair of hands to another.

For complete information about this and other Crane specialized hospital equipment, see your Crane Hospital Catalog or call your Crane Branch, Crane Wholesaler or Plumbing Contractor.

CRANE CO.

GENERAL OFFICES: 836 SOUTH MICHIGAN AVENUE, CHICAGO 5
VALVES • FITTINGS • PIPE • PLUMBING AND HEATING

New!

KIMBLE PIPETTES with cotton plug constriction

These new Kimble Pipettes combine Kimble quality with new efficiencies. Their new design prevents the cotton plug from slipping down into the main body.

The constriction is large enough for easy cleaning and in no way weakens the tube; nor does it alter flow characteristics.

You can order these new Kimble Pipettes from your hospital supply house, or write to us direct for a free copy of our latest catalog and price listing.

★
They are legible—
All markings are clearly indicated with Kimble permanent, *fused-in* filler.

★
They are retested—
Each pipette is tested during manufacture, then individually retested for accuracy before shipment.

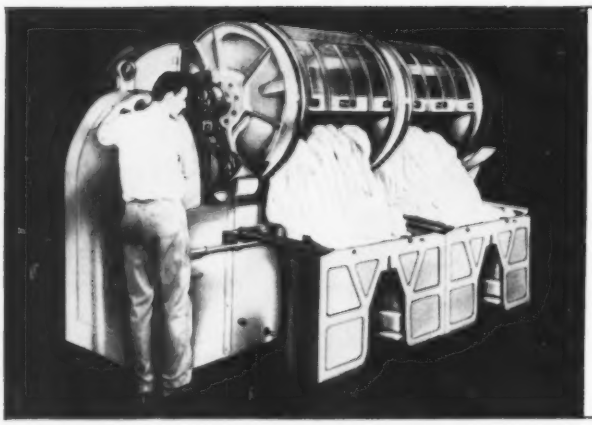
GLASCO PRODUCTS CO.

111 NORTH CANAL STREET, CHICAGO 6, ILLINOIS

Why more hospitals depend on American Washers than any other kind!

Just one of many big reasons: The opportunity to choose from a complete line of American Washers exactly the right one for their particular washroom operation! For example, the choice is yours between a Cascade Automatic Unloading Washer and a R.H.P. Cascade Washer (with Removable Horizontal Partitions). Or you can select a regular Side-Loading or End-Loading Cascade Washer in a size to meet your specific needs. American Automatic Washer Controls can also be obtained to match exactly with each washer size and washing formula.

Whether you are interested in one washer or need the planned installation of your entire washroom set up, call in your American Laundry Machinery Representative. Or write for free, illustrated catalogs on machines in which you are interested.



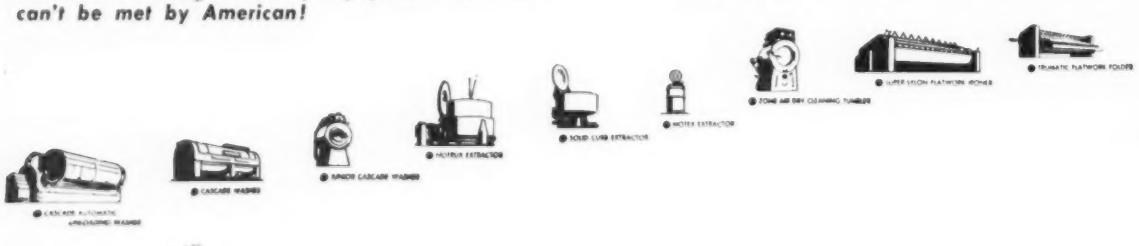
CASCADE UNLOADING WASHER. Push-button control empties entire load automatically in less than a minute. Full drop of work in open-pockets, plus "Two-Way Water Action" (bottom surge and top shower), assures top quality washing. Saves labor and washes more loads per day

Sizes: 42 x 54", 42 x 84", 42 x 96".

R.H.P. CASCADE WASHER (with Removable Horizontal Partitions), adds slide-out unloading to the advantages of open-pocket washing and "Two-Way Water Action." After load is washed, horizontal partitions are inserted. Load then slides easily from washer. Sizes: 36 x 54", 42 x 36", 42 x 54", 42 x 84", 42 x 96".

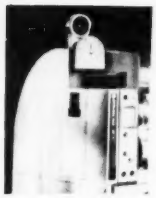
Also Cascade Side-Loading Washers without Removable Horizontal Partitions in sizes from 24 x 24" to 42 x 96".

There isn't a single laundry equipment need that can't be met by American!

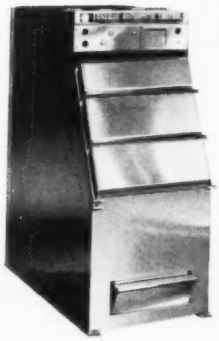


American
automatic washer controls for your choice:

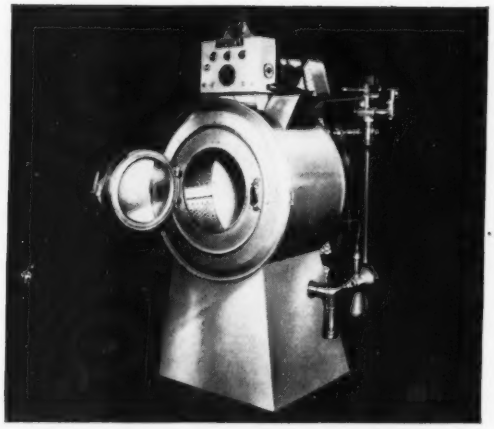
TYPE "W" CONTROL. Accurately times each bath, automatically drains bath and signals operator after bath has drained. This manually set Control saves washman's time and prevents overruns.



CASCADE SEMI-AUTOMATIC CONTROL. Metal formula plate governs operations of entire washing formula automatically, except addition of supplies. For addition of supplies, Control stops timed cycle and signals operator.



CASCADE FULL-AUTOMATIC CONTROL. Takes washer through complete washing formula automatically. Governed by tamper-proof, unalterable metal formula plates which are prepared specifically for each formula. Admits water to correct level, regulates temperature, adds supplies, times and drains baths. When load is washed, signals operator by both light and whistle. Saves washman's time and eliminates chance of human error. Gives you *uniform* washing with less water and supplies.



30 x 15" JUNIOR CASCADE WASHER WITH RINSOMATIC CONTROL. You get quicker and easier washing of your small lots in this compact, easy-to-operate washer. Dry weight capacity 25 lbs. Rinsomatic Control automatically times washing cycle, admits and drains each bath, signals for supplies, rinses automatically, signals when load is washed. Saves washman time and steps.

Other American Cascade End-Loading Washers, 36 x 18" (50 lbs. dry wt. capacity), 42 x 24" (100 lbs. dry wt. capacity).

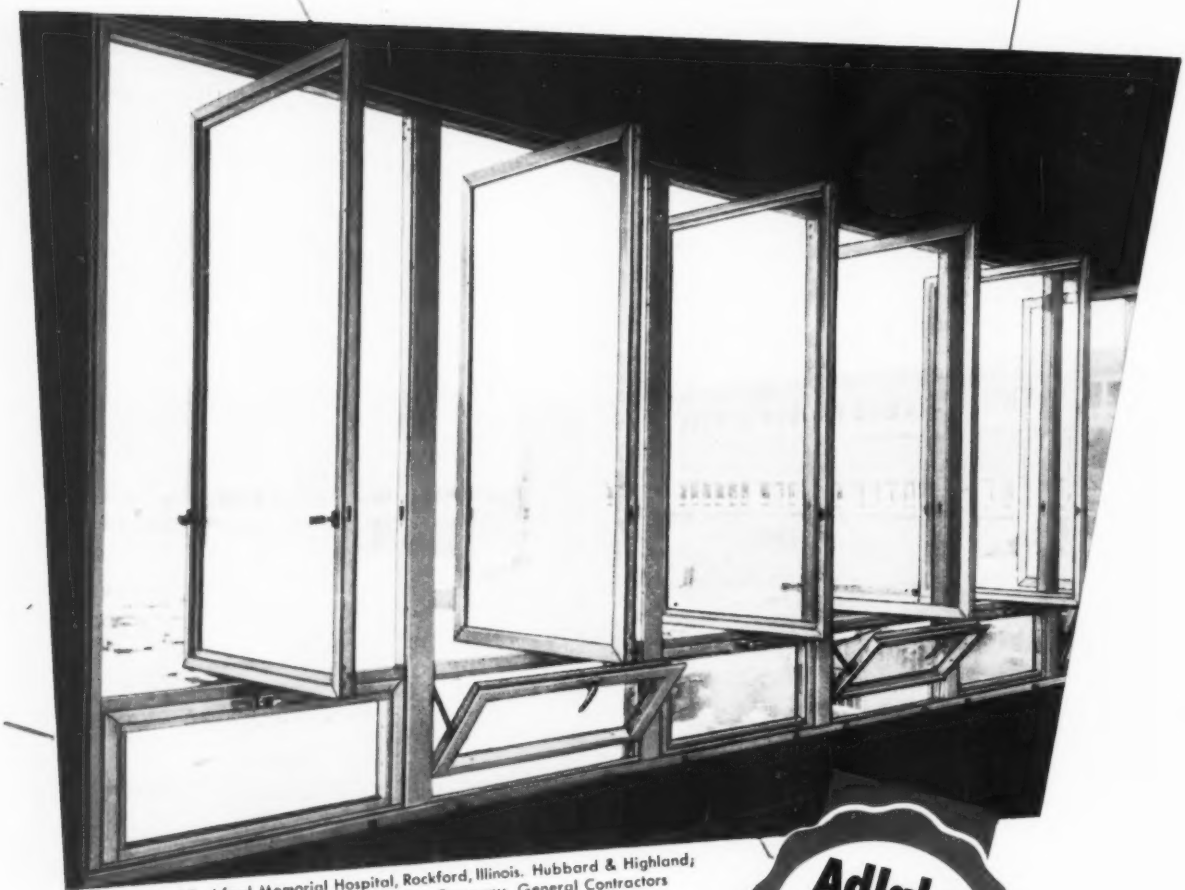
You can depend on this man!

He's your American Laundry Consultant, well-trained in hospital laundry operation. As he represents the World's Most Complete Line of Laundry Equipment, you can rely on his unbiased advice in your selection of equipment that's *just right* for you. Your American Consultant can help solve your laundering problems because he provides you with American's many years of experience in planning and equipping hospital laundry departments of every size. Contact American for his specialized assistance at any time... without obligation, of course.

The **AMERICAN**
LAUNDRY MACHINERY CO.
CINCINNATI 12, OHIO

World's Largest, Most Complete Line of Laundry and Dry Cleaning Equipment

Another **Adlake** aluminum window installation



Interior view of Rockford Memorial Hospital, Rockford, Illinois. Hubbard & Highland; Perkins & Wills—Architects. Security Building Company, General Contractors

- Minimum air infiltration
- Finger-tip control
- No painting or maintenance
- No warp, rot, rattle, stick or swell
- Wool woven-pile weather stripping and exclusive patented serrated guides

Adlake PROVEN QUALITY WINDOW

This window meets or exceeds all quality industry specifications for aluminum windows.
The Adams & Westlake Company
Elkhart, Indiana

97th year of serving the transportation and building industries

The Adams & Westlake Company

Established 1857 • ELKHART, INDIANA • Chicago • New York

Also Manufacturers of ADLAKE Mercury Relays and ADLAKE Equipment for the Transportation Industry

Small Hospital Questions

Hospital Care for Employes

Question: When our own employes get sick, should we give them free hospital care? Should the doctors on our staff take care of them without charging fees?—E.A.P., Mich.

ANSWER: Not many hospitals today provide free care for employes except under unusual circumstances. Instead, many hospitals have enrolled their employes in Blue Cross plans under which hospitalization benefits are provided as in the case of other members. Some hospitals which formerly provided free or part-free care for employes paid the employe's membership fee in Blue Cross when the switch from free care was made. Some hospitals still provide care at discounts ranging up to 50 per cent, depending on the length of service and other individual factors.

The custom of furnishing medical care without charge to hospital employes dates from the time when hospital employes were paid less than the prevailing wage for comparable jobs in industry. Under these circumstances it was thought fitting that staff service should include hospital personnel; in many hospitals employes are still cared for free or at nominal fees by staff members. However, as better business procedures have been introduced in hospitals and hospital wages have increased, it appears less necessary for doctors to offer such service on a free or part-free basis. Many hospitals operating in areas where Blue Shield or other prepayment plans are in operation have enrolled employes in such plans, thus putting them on a self-sustaining basis for medical care.

To Enlist Doctors' Interest

Question: Our doctors don't seem especially interested in the general welfare of the hospital—especially its financial problems. It has seemed to us the best way to engage their interest would be to let them share the trustees' policy-making responsibility. Do you agree?—F.R.L., Neb.

ANSWER: The question appears to suggest that doctors should be appointed to the board of trustees. While there are some who argue in favor of such appointments, the majority opinion is against having doctors on hospital boards, for reasons that have been stated again and again in the literature and at hospital meetings. Short of actual board membership, however, it is possible to give members of the medical staff a share in hospital policy-making responsibility through such means as the joint conference or board-staff committee, staff attendance at board meetings, presentation of financial and other administrative problems at staff meetings, and other liaison methods. Certainly, these and any other means that can be developed to give the doctors a sense of responsibility for the hospital's success are highly desirable.

Determining Bed Needs

Question: Our board of trustees is split on the question of whether additional beds are needed in the community and should be furnished through a building program at our hospital. The hospital is crowded most of the time and I feel that we could certainly use additional beds, but some members of the board fear a business depression and are unwilling to assume responsibility for expansion. Under these circumstances, how can we proceed to solve our problem most intelligently?—D.J.H., Ind.

ANSWER: The first step, if you have not already taken it, would be to consult with the hospital planning authority in your state. The state survey should show whether or not your community and the surrounding area appear to be adequately furnished with hospital beds in the various categories. This information is available and should be useful to you, whether or not your board would consider applying for state or federal aid through the state hospital authority, in case an expansion program seemed desirable.

In addition, you should communicate with chamber of commerce, real estate, trade association, farm bureau, and other groups in the area about their population forecasts, development programs, and other data that may help you determine what future needs for hospital facilities in the community are likely to be. The facilities and future plans of other hospitals that may be serving the same area should also be investigated, since these may have an effect on the demand for your facilities.

If none of these efforts produces a clear answer to the problem, your board might consider employing a hospital planning consultant to make an intensive survey of the area's hospital needs as a guide to future action for your institution.

Personnel Turnover

Question: Following our last annual audit, the auditor expressed concern about our personnel turnover rate and suggested we make a job evaluation and salary study, comparing the rates paid for various hospital positions with rates paid for comparable jobs in other occupations. Is such a study advisable?—E.W.M., Wash.

ANSWER: Certainly, such studies are in line with up-to-date personnel practice in hospitals, as well as in industry. Properly conducted job evaluation and salary administration studies and programs nearly always point the way to improved personnel practice, better human relationships within the hospital, and consequently greater efficiency. However, it should not be assumed, without full investigation, that the high turnover rate is caused by low salaries in competition with other industries, even if this is found to be the case. The job evaluation and salary studies should be accompanied by study of employe attitudes, and especially by "exit interviews" with departing employes to determine why they were dissatisfied with their jobs. In most such studies, salaries are found pretty far down the list of causes for dissatisfaction; thus salary adjustments alone might not solve the problem of turnover.

Conducted by Jewell W. Thrasher, R.N., Frazier-Ellis Hospital, Dothan, Ala., William B. Sweeney, Windham Community Memorial Hospital, Willimantic, Conn.; A. A. Aita, San Antonio Community Hospital, Upland, Calif.; Pearl Fisher, Thayer Hospital, Waterville, Maine, and others.

3 Great Baby Incubators

1 ARMSTRONG DELUXE H-H (Hand-Hole Type) INCUBATOR

Truly a beautiful, big, deluxe Baby Incubator—big enough for a 26″ baby. Designed and built to sell at a low price. Thick, transparent Plexiglas plate set in steel frames on all four sides. Safety glass top.* The one low price includes big 4-caster cabinet. Nebulizer, tilting bed, foam rubber mattress, oxygen control for *both* high and low concentrations. Normal humidity control. Simple design, simple operation, easy cleaning. A bigger Incubator for the larger term baby or the critically small premature baby.

2 ARMSTRONG X-P (Explosion-proof) INCUBATOR

The FIRST explosion-proof baby incubator ever built and the FIRST to be tested and approved by Underwriters' Laboratories for use wherever explosive gases create a hazardous atmosphere. SAFE in the delivery room. SAFE in the surgery. SAFE for asceptic transportation of infants from delivery room to nursery.

3 ARMSTRONG X-4 (Nursery Type) INCUBATOR

The original Armstrong baby incubator designed for safety, reliability, simplicity of operation, low operating cost and low initial cost. Experienced-perfected and hospital-proven throughout the world. The X-4 was the first Baby Incubator ever to be tested and approved by Underwriters' Laboratories and is still the low-cost Baby Incubator of choice for general nursery use.

*Scale not furnished as standard equipment since one scale will serve several incubators. Can be supplied as an accessory.

Write for complete details on any or all of these 3 Armstrong Baby Incubators.

THE GORDON ARMSTRONG COMPANY, INC.

Division DD-1 Bulkley Building, Cleveland 15, Ohio

Distributed in Canada by Ingram & Bell, Ltd.

Toronto • Montreal • Winnipeg • Calgary • Vancouver

BACK OF EVERY ARMSTRONG BABY INCUBATOR IS OVER 20,000 INCUBATORS' WORTH OF EXPERIENCE. SINCE 1943 THE SELLING PRICE TO YOU OF THE ARMSTRONG X-4 BABY INCUBATOR HAS BEEN INCREASED LESS THAN 3½%.

wire from Washington

CONVERSATION ON CAPITOL HILL

With Congress reopening shop after a five-month recess, and the Eisenhower administration desperate to get through some impressive domestic legislation before the fall elections, most predictions are that big things are about to happen in Washington.

Maybe so. But a long look at the facts—including political—suggests that this Congress won't do much to help or to hinder hospitals between now and midsummer when it adjourns. There will be words, and threats and promises—but not many new laws.

For one thing, the political lineup itself is too delicate to allow for much vigorous action. With the Republicans holding a bare majority of the House, and actually outnumbered in the Senate, the President will have to depend on Democrats to enact even the bare framework of his program. It is reasonable to expect that the Democrats won't want to overstrain their cooperation. That might leave the Administration with a dazzling record of accomplishment to display in November.

The Democrats recall, too, that they received little help from Republicans in the years when Mr. Truman wanted his own bright record in domestic legislation, including several fundamental changes in the nation's medical care and hospital programs.

Awaiting Congress' pleasure, as usual, are scores of bills that could make a great difference to hospital boards and staffs. Most important are omnibus bills to underwrite prepayment plans and proposals vastly to enlarge the Veterans Administration's medical program. It is a safe bet that these schemes for drastic change will stay right where they are now—buried in Senate and House committees.

MILITARY DEPENDENTS

In fact, of all the ideas that might be of real significance to hospitals, only one appears to have a reasonable chance of becoming law. This is the proposal, long under consideration, to clarify, broaden and make uniform the provision of medical care and hospitalization for dependents of military personnel.

If this issue can be compromised, the result would be hundreds of thousands of civilians going to civilian instead of military hospitals, and other hundreds of thousands under insurance protection for their hospital bills.

Legislation prepared by the Defense Department would:

1. **Have Congress redefine** the relationship required before a person is certified as a dependent of a man in uniform. Now the individual services make their own ground rules on dependency—and they can change them at will.

2. **Straighten out** the military budgets, so all medical care costs, including those of civilians, can be determined at any time.

3. **Have military hospitals** care for all dependents who can reach them, but restrict the type and amount of treatment.

4. **Authorize all other dependents**—in excess of a million—to see private physicians and receive care at private hospitals, with the government paying most of the cost directly to doctors and hospitals.

American Medical Association and American Hospital Association would willingly support the department on the first three points, ensuring that there would be little or no opposition in Congress.

On points 3 and 4, the A.M.A. proposes an approach from the opposite direction. Whereas Defense Department would turn over to private care only those dependents who couldn't be handled by the military, the A.M.A. would turn over to the military only the dependents who couldn't be handled by private physicians and hospitals. This procedure, in the A.M.A.'s opinion, would prevent the military medical departments from building up a vast new hospital program to care for civilian dependents.

To date the Defense Department has not reacted formally to this suggestion.

Not only Defense Department, but the House and Senate armed services and appropriations committees are anxious to straighten out the dependent medical care situation. Furthermore, it could be done at little extra cost. Thus, unless time runs out, there appears some possibility that a bill along these lines will be enacted.

INDIAN HOSPITALS

A few other bills of less significance in the hospital field also may be jarred loose from committees and enacted.

Almost any day now the House is expected to pass legislation removing the Indian hospitals from control of the Interior Department's Indian Bureau and turning them over to U.S. Public Health Service. This legislation was reported out of committee last session over the objections of Mrs. Hobby and her Department of Health, Education, and Welfare.

Senator Thye of Minnesota is pressing hard for the Indian bill in the Senate and so far has not encountered serious opposition.

TAXES AND SOCIAL SECURITY

Of indirect interest to hospitals is the proposal, favored by the House ways and means committee, to allow a larger tax deduction for medical expenses. Under present law deductions can't be taken unless they total more than 5 per cent of taxable income, then only for the amount exceeding 5 per cent. The committee wants to lower the percentage, probably to 3 per cent, and to lift the present $5000 maximum limitation on total medical costs.

Plans now are to incorporate this idea in the omnibus

tax change bill, a procedure that has disadvantages as well as advantages. If the omnibus bill gets bogged down on technicalities, the medical deduction item also is lost for this session. But if all goes well with the tax bill, the deduction item will likely ride along to the White House.

Another omnibus bill—on social security—carries a few words to which physicians are making loud objection. The bill under consideration would extend coverage to almost all self-employed groups, including physicians, dentists, veterinarians and attorneys. The physicians don't want to be covered, nor do the dentists or lawyers. Social security planners want to get everyone possible under coverage. They can't see the physicians' argument (a) that most doctors don't retire until well after 65 years, and (b) that physicians and the others should be allowed to set up their own pension plans, supported by money on which income tax payment is deferred until the money comes back in the form of pensions.

Chairman Charles Wolverton (R.-N.J.) of the House interstate and foreign commerce committee will do everything in his power to smooth the way for some sort of legislation to underwrite prepaid health plans. He is anxious to work from both ends—assistance to the companies and groups that are experimenting with catastrophic insurance as well as to the medically indigent families that cannot afford even basic hospitalization protection.

The committee last fall held a long series of hearings on federal and private medical research, and wound up the study with two days devoted to health insurance. Now the committee has scheduled another period of hearings for this month, when experts will testify on all phases of health insurance. Invited are the medical associations, labor groups, cooperative plans, and so on.

Although Mr. Wolverton is respected for his industry and sincerity, there is not much hope that Congress this year will be in the mood to pass the really comprehensive bill he has in mind. He may have the sympathy of his Democratic colleagues, but probably not many of their votes.

THAT V.A. PROGRAM

As usual, squabbles over the Veterans Administration medical program should produce much heat, but the prospects for light are not very good.

The V.A. believes it has answered all its critics already. It considers that a rewording of the hospital admittance form to obtain more financial information on nonservice-connected cases should satisfy everyone. That the critics are not appeased already is apparent. American Medical Association, with some support from Congress and a lot of support from the Budget Bureau, is calling for a basic change in philosophy regarding the government's obligation in nonservice cases.

Supporting Veterans Administration are most of the servicemen's organizations. For this session of Congress it looks like a tug-of-war, with the A.M.A. making some progress in educating Congress and the public but the veterans' groups doggedly blocking any drastic reform.

HILL-BURTON AWAITS FATE

With publication of the President's budget in a few days, directors of the Hill-Burton program will learn whether the hospital grants operation is due for a fast death or will be continued on indefinitely.

At last session, Congress cleared the way for an abrupt termination, if it should decide on one. "Split projects" are so restricted, under the new regulations, that any state's allocation may be cut between one-third and 50 per cent each of the next two years without stranding the projects.

Indications are that, regardless of what the budget says, Congress will make a minute study of the entire H-B operation before approving this year's appropriation. It will want to learn not only exactly where the hospitals are, but how they are being used.

NOTES:

Among new legislation for Congress to act on is a Defense Department proposal for federal medical scholarships. Defense argues that with the end of the doctor draft on June 30, 1955, it will need some new mechanism to obtain doctors. One year of federal service would be required for each scholarship year. Stipends would cover living expenses as well as tuition and other school costs.

A directive from the White House eliminates one injustice of the doctor draft law. Previously, a doctor would land in Priority IV rather than III if he had had as little as one day of active duty. Under the new directive "active duty" is interpreted to mean at least six months.

Dr. James P. Dixon, formerly Philadelphia health officer, will assist Dr. Edwin L. Crosby, the research director of the Hoover Commission's Medical Task Force. Dr. Dixon will be staff secretary.

Dr. Basil C. MacLean, director of Strong Memorial Hospital and professor of hospital administration at Rochester University, heads up a Hoover Task Force group assigned to dig out information for the commission on Veterans Administration. Other units, made up of three to five commission members, will look into the armed forces, U.S. Public Health Service, and other government medical programs, and over-all plans for integration of military and civilian medical services in case of war.

According to a World Health Organization committee, a psychiatric hospital should have these five "essentials": 1. Designed on the model of a village with patient units to care for no more than 10 each. 2. A hostess with "intelligence and an attractive personality." 3. Respect for the personality of the patient. 4. Psychiatric nurses not required to attend more than six patients. 5. Patients encouraged to form clubs.

The Manion commission, studying the relationship of U.S. to state and local governments, is attempting a national sampling survey of the situation. It will check into all federal-state programs, including Hill-Burton.

Nebraska, incidentally, is one step ahead of the Manion commission. At a Washington hearing a Nebraska representative said his state had stopped its public assistance medical care program after five years because the federal government was doing "too much meddling."

There are 34 Republicans in the House 65 years of age or older. If two of them should die this session and be succeeded by Democrats, the two parties would be absolutely even numerically.

The new report recommending Universal Military Training proposes that trainees, on completion of the course, would have no connection whatever with Veterans Administration. If injured during training, they would be compensated by the U.S. Employees Compensation Board and would pay for medical and hospital care after discharge out of the benefits received.

The Modern Hospital
JANUARY 1954

LOOKING AROUND

Wayfarer

AN EDITOR'S office—in this business, anyway—is a kind of feeding station where seeds of information and thought are dropped and picked up by visitors who fly in from all over. During the space of a few days last month, for example, we had visitors from Thailand, Australia, Mexico, New Zealand and India, not to mention the callers who come and go all the time from Britain, Scandinavia and the continent. Our favorite visitor in recent months, however, was an Italian lad of 20-odd whose calling card bore the name of a big manufacturer of institutional equipment in Milan. He wanted to see some American manufacturers and compare lines, he said, so we helped him arrange some calls, interested that so important a mission should be entrusted to such a young representative.

As the visit drew to a close our curiosity outran our politeness, as sometimes happens, and we finally asked the young man frankly what job he held with the company.

"I own it," he replied.

Not for Dimwits

LONG an accepted maneuver in business, the use of management consultants is becoming a familiar phenomenon in the hospital world. While this is probably a constructive development on the whole, it is understandable that hospital administrators should look upon it with some misgivings: It has often happened that when the consultant comes in, the administrator goes out. This kind of thing makes everybody nervous about management consultants—and sometimes, at least, with good cause. Hospital boards have been known to retain consultants as a ruse to get rid of administrators they don't want to fire out of hand. There must be an easier way.

Nevertheless, it seems likely that the use of consultants in hospitals will continue. Most hospital trustees today feel some anxiety about mounting costs and lagging revenues, or doctors' complaints about the management, or patients' complaints about the service, or all three. When, for good or bad reasons, the administrator is unable to resolve these anxieties, the board may decide, in all prudence, to call in a management consultant, who will prowl over the premises, cross-examine the personnel, comb through the records and, at length, render a report, of from 300 to 1000 pages, telling the board what is wrong and what ought to be done.

More often than not the management consultant, especially if he is a good management consultant, is right about what is wrong. There are several reasons for this. In the first place, like them or not, most management consultants are pretty bright; it is not a profession, like rag sorting, in which dim-wittedness is no handicap. Then, too, your management consultant is always a forest man rather than a tree man, and it often turns out that nobody else around the hospital has been looking at the forest; many institutions just go along from day to day without any clear sense of direction or purpose. The management consultant will insist on establishing and defining goals, a circumstance which makes it easier to measure performance.

Prowling and combing, the consultant and his staff are bound to uncover processes that are inefficient and people who are ineffective. Inevitably, these are examined in loving detail in the report, and here is where the men are separated from the boys among management consultants. Because he depends for his information primarily on people, and often on people whose self-esteem is at stake, if their jobs aren't, the consultant may easily be misled into magnifying minutiae or mistaking opinion for fact. He must make his own estimation of the truth on the basis of his own observations, and the hospital will suffer if he is very far off the mark.

If it is hard for the consultant to make an accurate judgment of the truth about what is wrong, it is much harder for him to determine what ought to be done. Clearer goals and better processes may encourage, but will not guarantee, improved results. Relationships that look tidy and efficient on an organization chart may be fuzzy in practice. In an organization of human beings, motivation is the key to performance, and motivation is an elusive thing. What improves it in one person may destroy it in another. It is the everlasting task of adminis-

tration to furnish motivation where it is lacking and to improve it where it exists, and it is the awful responsibility of the management consultant, when all is done, to judge whether administration is equal to the task. In this judgment the careers of hospital workers and the welfare of hospital patients are at issue. Thus the management consultant in the hospital needs a soul to match his brains. He must take guidance from God and conscience, as well as the balance sheet.

Old Stuff

SANDY is troubled over newspaper articles about Chicago doctors who are accused of fee splitting," said a letter that we saw the other day, written by a doctor's wife. "He thinks the practice is much to be deplored, but was concerned lest the publicity might be injurious, undermining the confidence of the laity in their own physicians. . . .

"Naturally, those who don't do it dislike to stir up the matter," the letter continued, "but it has become such a flagrant practice that some of our best physicians are speaking against it. . . . Dr. Lydstron has been writing in medical journals about the evil and he has convinced Sandy that all doctors must unite to stamp it out. He says it is bringing the practice of medicine down to the level of the street huckster and thinks those who give or receive commissions aren't likely to consider whether an operation is necessary. It's quite appalling, isn't it?

"Two Chicago physicians unearthed the truth, so far as Chicago men are concerned, by sending to 100 Chicago physicians and surgeons a decoy letter purporting to come from a downstate doctor who described himself as young and needing money. He wrote that he had a wealthy patient who would like to go to Chicago and that he (the fictitious country doctor) would like to bring this patient to the city for a consultation. Would there be a 25 per cent commission on the case?

"Of the 100 doctors written to, only 18 replied in the affirmative. There were 26 who replied, declining the offer. The remaining 56 doctors did not reply at all. Sandy says he received one of the letters but threw it into the wastebasket.

"I imagine any doctor who does give a commission in the future will be expelled from the medical society. He should be, of course, but the resulting publicity is bad for the whole medical profession."

Apparently, the bugbear of bad publicity held up the fight against fee splitting for nearly 50 years. The letter quoted here was written in 1904; it appeared recently in the column, "When Chicago Was Young," in the *Chicago Tribune.*

Ah, Charity!

HOSPITAL in Pennsylvania got an answer it wasn't looking for a few weeks ago when it made a fund-raising appeal to a wealthy citizen who had recently been hospitalized and, it turned out, hated every minute of it. Nevertheless, he offered to contribute if the hospital would mend its ways—on his terms. The proposition: He would donate $1000 for each member of the board of trustees who would resign immediately!

What's News?

THIS is not a time when anyone who wants to make friends in the hospital field should put in a good word for Albert Q. Maisel, the magazine writer, and we aren't going to try. His *American Weekly* articles on hospital nursing service were cheap journalism—an attempt to make a national scandal out of reported instances of bad nursing practice. This is the kind of thinking that makes a saloon fight and two burglaries into a crime wave.

The vigorous protests of hospital and nursing officialdom following publication of the Maisel articles were in order. A widely publicized letter from President Ritz Heerman of the American Hospital Association to the publisher of the *American Weekly,* especially, laid Mr. Maisel out in spades and was a pleasure to read. It would be a mistake, however, for hospital people to believe that any such protest will have the effect of preventing the appearance of other articles condemning hospitals and nurses, or that the nation's press will feature only constructive articles about hospitals—now or ever. It is crime, not good behavior, that makes headlines, and it is the breach of good hospital practice, not its observance, that makes magazine articles. The reason for this, of course, is that it is crime that is unusual, and therefore newsworthy, and it is bad hospital practice that is unusual, and therefore sensational. If many nurses behaved like the nurses in Mr. Maisel's articles, there wouldn't have been any articles.

The saving thing about these occasional outbursts of bad publicity on hospitals is that people generally understand and accept them for what they are, and not as the literal truth. This is not to excuse the distortions of truth that get into print, but it does suggest that the ill-effects of distortion are soon lived down in hospitals whose service is as good as it ought to be. Where service is bad, publicity performs the useful function of focusing attention on it—a necessary, if painful, first step toward reform. For hospitals, as for society, there is more to be lost by withholding information and cooperation from reporters, as it has now been suggested hospital people should do in an attempt to avoid further distortions, than by giving information freely and counting on truth to win the struggle with falsehood, as it has always done. Like most administrators and most nurses, most reporters are honest.

Higher Learning

UNDERSTAND you been to a workshop," our friend Anastasia said as she came into the office the other day. "Learn anything?" We said we had.

"You broke the rules then," Anastasia declared. She whipped out a book she was carrying and showed us the title. It was "The Workshop Way of Learning," by Earl C. Kelley. Anastasia flipped through the pages until she came to an underlined paragraph. "Read that," she commanded.

"We have not succeeded in answering all our problems," this said, "indeed, we sometimes feel we have not completely answered any of them. The answers we have found have only served to raise a whole set of new questions. In some ways we feel that we are as confused as ever, but we think we are confused on a higher level and about more important things."

WHO SHOULD DO SURGERY?

For small and large hospitals alike, standards for surgical staff privileges need to be redefined and clarified. Some will say the standards set forth here are too stringent, but when patient welfare is the goal there can be no "double standard" in surgery.

ROBERT S. MYERS, M.D.
Administrative Assistant
American College of Surgeons

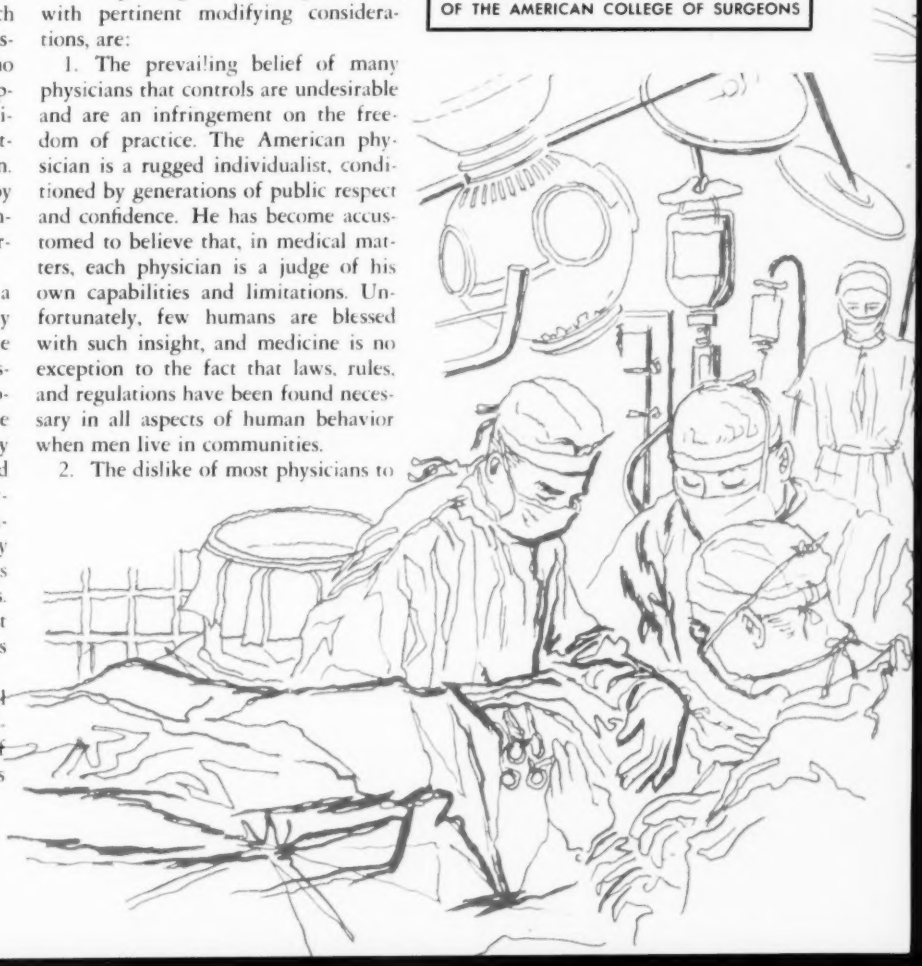
THE determination of surgical staff privileges is probably the most difficult and important decision which confronts the medical staff of any hospital. This is so because there are no universally recognized and easily applied standards for determining privileges which are accepted wholeheartedly by the entire medical profession. Moreover, the practice of surgery by those who are unqualified and incompetent causes increased morbidity, mortality and expense.

The last 50 years have witnessed a remarkable growth in the scope, safety and public acceptance of surgery. The scientific advances in diagnosis, anesthesia, surgical technic, drug and supportive therapy of the last 20 years have so increased the complexities of surgery that surgical residency training has had to be improved and lengthened. However, during this period the qualifications for surgical staff privileges in many hospitals have not kept pace with this recognized need for better surgeons. In the interest of the patient, present standards for surgical staff privileges should be redefined and clarified.

The gauges for measuring surgical performance are not precise. The intangibles inherent to the practice of medicine have fostered several obstacles to an elevation of standards for surgical staff privileges. These impediments, with pertinent modifying considerations, are:

1. The prevailing belief of many physicians that controls are undesirable and are an infringement on the freedom of practice. The American physician is a rugged individualist, conditioned by generations of public respect and confidence. He has become accustomed to believe that, in medical matters, each physician is a judge of his own capabilities and limitations. Unfortunately, few humans are blessed with such insight, and medicine is no exception to the fact that laws, rules, and regulations have been found necessary in all aspects of human behavior when men live in communities.
2. The dislike of most physicians to

THIS ARTICLE HAS BEEN READ AND APPROVED BY THE BOARD OF REGENTS OF THE AMERICAN COLLEGE OF SURGEONS



judge a colleague. Medicine is different from most other professions, businesses, and occupations in that the doctor must necessarily work intimately with his patients and colleagues, and avoidance of unnecessary friction is desirable for the welfare of the patient and the peace of mind of the physician. Doctors do not advertise or solicit. They depend on the good will of their patients and colleagues for practice. It is not surprising, therefore, that most physicians find it distasteful, as well as extremely difficult, to sit in judgment on the actions of their fellow practitioners.

3. The unrealistic adherence to the time-honored concept that a doctor's license to practice implies fitness for all branches of medicine. The very complexity of modern surgery demands ability, highly specialized training and adequate experience in the individual who elects to do surgery. It is of interest that the courts recognize this point, as witnessed by a recent decision in Ohio: "A license issued to a physician gives to him a mere naked privilege to practice medicine or, in other words, an immunity from punishment because of practice without a license." And further, "It would project the doctrine of freedom and equality into unwarranted areas to hold that one could practice major surgery with facilities furnished by the city when he has nothing more than a diploma from medical school and a certificate from the state board of medical examiners to warrant his skill in that field. A lawyer with similar credentials would not be employed to make out a complicated income tax return, a teacher with the equivalent of this would not be employed to teach calculus or theology, and so we might add cases ad infinitum when special training is prerequisite to employment in specialized fields."

NO DOUBLE STANDARD

4. The erroneous belief that a double standard for surgery exists. The view is all too frequently expressed that the same rigid standards for surgery should not be demanded for the small, or rural, hospital as for the large, or urban, hospital. This implies that the patient treated in one hospital is not entitled to as good care as the patient treated in another hospital. If this idea is carried to its logical conclusion, it would surely mean that those who advocate the double standard of surgery are not interested in the welfare and safety of their patients, or they would send them to the institutions with the highest standards of surgery. Actually, certain definitive and elective surgical procedures requiring specialized skills and technics (diagnostic, surgical and nursing) should be done only in those hospitals capable of providing these services. However, the same rigid standards for surgery are to be expected for all hospitals, regardless of size or location, which undertake to treat identical surgical conditions.

NOT LIKE PAJAMAS

5. The difficulty of classifying surgery as major, intermediate and minor. This time-honored classification, which was devised to facilitate the assignment of privileges to surgeons, is based on the erroneous assumption that surgery comes in certain sizes, like pajamas—large, medium and small. This is not so. All surgical procedures require judgment as well as technical proficiency, and such qualifications do not come in "intermediate" or "minor" quantities. All surgery should be considered of major significance, and the physician permitted to do surgery should be qualified by training, experience and ability. This concept does not negate the proper training of surgical residents where the pupil is under the constant supervision of qualified attending surgeons, who are legally and morally responsible for the welfare and safety of the patient.

6. A lack of any clear-cut formula for judging the individual surgeon's fitness to perform surgical procedures. It has always been held by the American College of Surgeons that the granting of surgical privileges should be a matter for the credentials committee of each hospital to determine on the basis of the training, experience, ability and the moral fitness of each individual applicant, but it is much easier to talk about these qualities than to define and apply them. There is a need right now for definite standards which can be applied easily.

Granted that all the foregoing factors affect the determination of surgical staff privileges in our hospitals, it would seem advisable that the standards be clarified for the guidance of medical staffs. These standards should be considered to be minimum, and it should be understood that some hospital staffs will use more rigid qualifications.

In any consideration of minimum standards for surgical staff appointment the basic truth must be emphasized that the patient's welfare and safety are the paramount factors. On this ground alone, only the fully qualified surgeon should be granted any surgical privileges, and no surgery should be done by any doctor not qualified to do all surgery in the particular field in which he has been trained. (Again, this does not apply to resident training programs.) This represents an ideal which the present inequitable distribution of surgical specialists does not permit to be attained at this time. Until such an ideal can be realized, some method must be followed to permit surgeons who have attained satisfactory proficiency in certain types of surgical procedures to practice these procedures in the hospital. In other words, a surgeon should be placed in either of two classifications: Full Surgical Privileges or Limited Surgical Privileges, depending on the qualifications and ability of the individual surgeon to perform *specified* surgical procedures. This would eliminate the entirely illogical and confusing classifications of "major," "intermediate," and "minor" surgery, and relieve the profession of the untenable position that an appendectomy is "major," whereas surgery of the hand, in which incompetent surgery may cause vastly more disability and economic loss to the patient, is "minor."

DEPTH OF TISSUE POOR CRITERION

The depth of tissue beneath the body surface should not be the criterion by which surgery is classified, nor should second-rate classifications such as "intermediate" or "minor" be set up as a preserve for those physicians who are not adequately qualified to do surgery. When done by the inexperienced, surgery of the superficial parts can be as dangerous and formidable as procedures which are held to be "major."

It is true that there is no single mold for the making of surgeons, but it has been demonstrated that the production of large numbers of well trained young surgeons is best accomplished by integrated, progressive, supervised and accredited residencies. Completion of such a program by a surgeon can be confidently regarded as an index of training.

The following minimum standards for determining surgical privileges are offered as a guide for the medical staffs of hospitals in the United States and Canada, where the medical professions are accustomed to think in terms of hospital accreditation:

Full Surgical Privileges. A surgeon admitted under this classification would

be permitted to perform all surgery within his chosen special field of surgery if he has met any of the following conditions:

1. Certification by the appropriate American specialty board.

2. Fellowship in the American College of Surgeons, classified as to specialty. In Canada, designation as a Fellow of the Royal College of Surgeons of Canada.

3. Equivalent qualifications of (1) or (2), as attested to by *eligibility* for certification or fellowship. Such eligibility is usually dependent upon adequate, formal, progressive training of specified duration in a residency which is approved by one of the following agencies: an American specialty board, the Council on Medical Education and Hospitals of the American Medical Association, the American College of Surgeons, and, in Canada, the Royal College of Physicians and Surgeons of Canada.

4. A minimum of 10 years of acceptable practice of surgery in the community, preceded by one year of formal and approved surgical residency training; or, in lieu of this training, five years' preceptorship under a surgeon acceptable to the hospital's credentials committee, and unqualified recommendation by that preceptor. Since this method of acquiring surgical training is now recognized as inferior to training secured in an adequate and approved residency, it is desirable to set some time limit, such as 1955 or 1956, after which such training will not be acceptable for new applicants for surgical privileges.

COLLEAGUE CAN JUDGE FITNESS

5. A minimum of 20 years of acceptable practice in the community for those older and highly capable surgeons who have had no formal residency training or preceptorship. The capabilities of such surgeons can be determined by the individual surgeon's colleagues on the medical staff by review of the hospital records and by assessment of tissue committee decisions for evidence of adequate surgery. In this category a time limit is also desirable for new applicants for privileges.

Limited Surgical Privileges. A surgeon admitted under this classification would be permitted to perform those procedures in which he has had training and experience as attested to by any one of the following:

1. A minimum of five years of acceptable practice of surgery in the community, preceded by one year of formal and approved surgical residency training; or, in lieu of this year, three years' preceptorship under a surgeon acceptable to the hospital's credentials committee, and unqualified recommendation by that preceptor.

2. For those who have not practiced five years or have not had an approved preceptorship, either of the two following requirements should be adopted: (a) two years of approved surgical residency training, or (b) one year of approved surgical residency in addition to a two years' mixed or general practice residency.

MIGHT BE ABOLISHED

In metropolitan areas where there is an adequate number of fully qualified surgical specialists there would seem to be little justification for Limited Surgical Privileges. In other areas, when the number of surgical specialists becomes adequate, Limited Surgical Privileges might be abolished at the discretion of the medical staff and governing board of the hospital.

Further steps are necessary to ensure the most careful selection of surgeons to be granted privileges on the hospital staff. Eternal vigilance by the individual surgeon and the medical staff is essential to maintain the highest possible surgical standards. To accomplish this end, the following additional safeguards are suggested:

1. The medical audit of the hospital practice of every physician, both medical and surgical. It is an accepted, as well as required, procedure to conduct a financial audit of the books of business institutions, including hospitals. Logic would demand that the medical and surgical care of patients be audited. By such means the quality of each physician's work can be determined, and an equitable basis for determining surgical privileges provided, on the basis of demonstrated competence.

2. More exact methods of ascertaining the surgical experience of surgeons who have applied for surgical privileges in a hospital where they have not practiced previously. The qualifications of any unknown or untested applicant for surgical privileges should be rigidly scrutinized by the credentials committee of that hospital. If he has practiced in any hospital, a surgical list, including results of surgery, attested to by that hospital, should be obtained for all procedures done by the applicant during the preceding twelve months, and a statement concerning the quality of his surgery should be obtained from the responsible surgeons of that hospital. With this information in hand, the credentials committee is in a better position to judge the quality of the applicant's surgery and to make some estimation about his qualifications.

3. More exact information about the surgical experience of the newly graduated resident who applies for surgical privileges in a hospital where he has previously had no training or staff privileges. A surgical list should be obtained, showing this applicant's work during his entire residency training, as well as recommendations from the men who supervised him during his residency training.

4. More adequate supervision for all newly accepted members of the surgical staff. Any recent appointee to the surgical staff of a hospital should be required to have his surgical work supervised by a qualified member of the surgical staff who has Full Surgical Privileges or by a committee appointed by the medical staff. This period of supervision should not be less than six months in duration and probably not more than 12 months. It should be possible within this span of time to judge the new surgeon's capabilities, and he should then either be granted unsupervised surgical privileges for a certain specialty or list of procedures, or be dropped from the department.

RESIDENCY IS BEST TRAINING

It may be questioned why the foregoing guide for surgical staff privileges does not allow more recognition for surgical training secured solely by preceptorship. It is now well recognized that the training obtained in an approved and adequate residency is almost invariably superior to preceptorship training, and it is recommended that the future surgeon obtain adequate training in such a residency before beginning his practice. In certain specialties, such as ophthalmology, otolaryngology, urology, and proctology, where instrumentation is an essential part of the training of the surgeon, the preceptor may well have much to offer, but only in addition to basic and broad residency training.

There will undoubtedly be some physicians who will regard these standards as too stringent. However, if the welfare and safety of the patient are taken as the goal for which every physician should strive, measures designed to lead to that goal should not be considered unduly restrictive.

Michael Reese Hospital Reports

What Happens When the Hospital Goes Home

MORRIS H. KREEGER, M.D.
Executive Director, Michael Reese Hospital, Chicago

HOSPITALS have come a long way in expanding and extending their community service from the limited area of in-bed patient care which in former years constituted the be-all and end-all of the hospital's activities. As new needs and new areas of usefulness in medical care have developed, hospitals in the United States have responded by broadening their concept of their responsibility to the community. Thus, to the traditional and basic in-bed patient program has been added, as properly belonging in the hospital's sphere of service, accident rooms, clinics for indigent outpatients, diagnostic and treatment facilities for private ambulatory patients, prenatal clinics, well-baby clinics, child guidance clinics, dental care programs, rehabilitation centers, medical and paramedical education, and research.

In recent years another new area of needed service has become apparent, *i.e.* home medical care for the medically indigent patients for whom the hospital has assumed medical responsibility, and some hospitals have already responded to the need by inaugurating such a service. This report details the experience of Michael Reese Hospital, Chicago, with its home medical service program.

Frank discussion of patient's condition by social worker helps son and daughter-in-law understand and cope with family problems.

NEED FOR HOME SERVICE

The need for establishment of a home medical service program for indigent patients generally arises from one or more of four basic factors:

1. Shortage of hospital beds.
2. High cost of construction of additional hospital facilities.
3. High cost of hospital care.
4. Psychological and emotional advantages in taking care of certain types of patients at home.

Almost every voluntary hospital that has been faced with the dual problem of bed shortage and insufficient funds for construction of additional facilities has had to institute some controls governing the admission and discharge of patients. The medical staffs of these hospitals are usually asked not to refer patients for hospital admission who can be taken care of at home, and to

In its four years of existence the home care program has proved of great value in filling the gap between ambulatory clinic care and in-bed care in the wards of Michael Reese

Social worker and premature clinic nurse use the automobile purchased by woman's board for their visits to the patients.

discharge patients from the hospital as soon as they no longer need the facilities of the acute general hospital.

Many hospitals do not permit patients to remain beyond a certain maximum time, such as two or three months, unless the attending physician can justify a more prolonged hospital stay. For the private patient, who can afford to have his personal physician take care of him at home, these restrictions rarely work any undue hardship. But for the medically indigent clinic patient who becomes too ill to continue to come to the clinic yet does not require hospitalization in the wards of the hospital, or for the ward patient who is found to have a chronic, long-term or terminal illness which the hospital cannot continue to treat in the hospital, the situation is of the most serious import because these patients cannot afford private medical care in their homes. Nevertheless, the hospital is obliged to make the best possible use of its ward beds, and of the limited funds available for the care of ward patients, by limiting ward care to those patients who require hospitalization for proper treatment or who are most likely to benefit from a relatively short period of hospitalization.

Further to complicate the picture, there are certain patients who would prefer to be taken care of at home, and whose families would also prefer it, even if hospital beds were available. These are the patients with chronic, long-term or terminal illnesses who do not want to spend their remaining months of life in a hospital.

And so we have the problem of what to do with these indigent patients for whose medical care the hospital has assumed responsibility—the clinic patients who become too sick to continue to come to the clinic and yet are not admissible to the wards; the ward patients who require continued long-term bed care which the acute general hospital cannot supply, and the chronic or terminal patients who prefer to be at home with their loved ones. The solution of this problem is home medical service.

DEVELOPMENT OF THE PROGRAM

Since 1942 Michael Reese Hospital has had a limited home care program for cardiac patients.[1] In 1949 it was decided to extend home care to all clinical types of patients, but to limit the service primarily to long-term or terminal cases. With approval of the proposed program by the medical staff, the board of directors, and the Chicago Medical Society, the present home medical service program was launched.[2]

The program started with a minimal staff and a minimal budget, but instead of tracing its detailed development here I will summarize its present status. The program is under the jurisdiction of the outpatient department. Ten clinic physicians are on the home care panel, each physician being responsible for covering a specific area of the city corresponding to the area in which he lives or has his office.

A full-time social worker and a part-time clerk are assigned to the program. The clinic dietitian consults with the doctors on special diets and makes home visits when necessary, but her services are not charged to the home medical service budget. Medical and surgical consultants are available to visit patients at home on request of the home medical physicians. The records of each patient are periodically reviewed by the head of the service from which the patient was referred, and conferences about the patient's care are arranged whenever necessary.

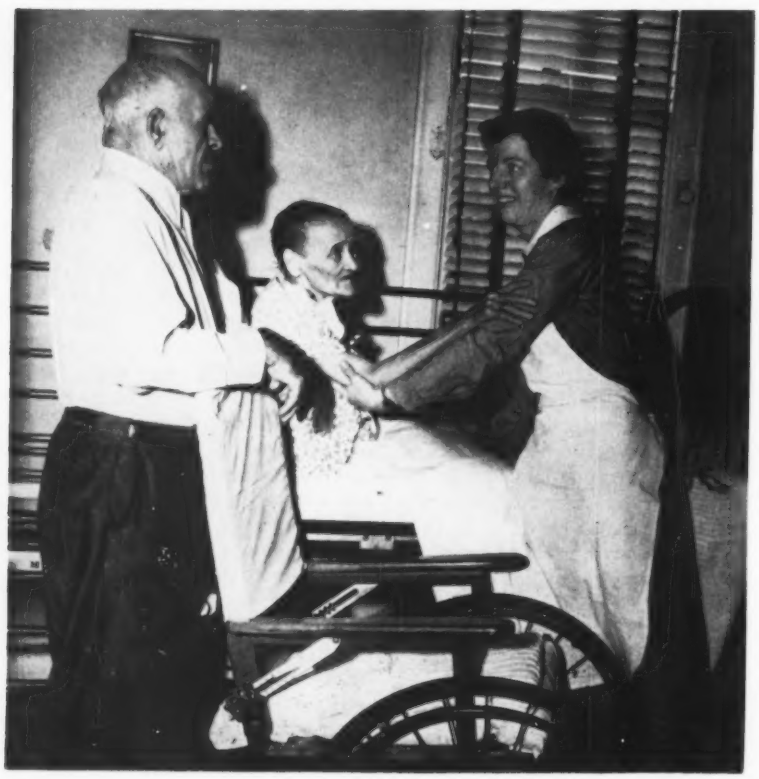
HOW IT WORKS

The original referral to the home medical service is made by the clinic or ward physician in charge of the case. Of the 129 patients treated in 1952, 95 had been referred from the clinics and 34 from the wards. The referral is sent to the social worker who determines whether home conditions are suitable for the proper care of the patient. If they are not, she discusses the case with the referring doctor and some other disposition is decided on. If home conditions are suitable, the case is referred to one of the home care physicians in accordance with the residence of the patient.

The home care physician assumes complete professional responsibility for the medical treatment of the patient. He reviews the clinic or ward chart, consults with the referring clinic or ward doctor, and discusses the social aspects of the case with the social worker. He may visit the patient at home as often as he deems necessary, which may vary from two to three times a week to once every two or three weeks. After each visit he prepares a report of the patient's condi-

[1] Supported by the Kudish Heart Fund.
[2] Supported by the Jewish Federation of Chicago, Chicago Community Fund, Illinois Division of the American Cancer Society, Chicago Community Trust Fund, Kudish Heart Fund, Gmilas Chesed, Gmilas Chassdim, Woman's Board, and Chicago Ivreyoth.

Above: Keystone of program is the corps of Mandel Clinic doctors who make regular home visits. Photograph shows Mrs. C. in a hospital bed provided by the clinic. Below: Visiting nurses train relatives in caring for household patients. In this photograph, Mr. C. is being instructed by the nurse in the technic of transferring his wife from her bed to the wheel chair.



tion, and the report is appended to the clinic or hospital chart. If the patient's condition warrants, the home care physician may refer him to the hospital, or he may request nursing care in the home; laboratory tests; special equipment such as a hospital bed, wheel chair, bedpan or urinal; surgical dressings, and so forth.

The social worker arranges for home nursing care through the Chicago Visiting Nurses Association, and the needed supplies and equipment are sent out from the hospital or are obtained from various supporting community agencies. Housekeeping services are similarly arranged for when needed. Patients requiring electrocardiograms, x-ray examinations, or similar tests are brought to the clinic by taxicab if they are well enough to be transported; if not, the tests are done in the home by commercial medical laboratories. Specimens such as blood, urine, stool and sputum are brought to the hospital laboratories for examination. Prescriptions given to the patient are filled by neighborhood druggists who send their bills directly to the hospital outpatient department for payment.

Too great emphasis cannot be given to the teamwork involved in a service of this sort. Doctors, social workers, dietitians, patients' families and relatives, and outside agencies, all work in the closest possible way to meet the total medical and social needs of the patients.

SERVICE STATISTICS FOR 1952

One hundred and twenty-nine patients were treated on the home medical service in 1952. The following clinical conditions were represented:

Clinical Condition	*No. of Patients*
Cancer	45
Cardiac	61
Circulatory, without major cardiac symptoms	2
Blood dyscrasia	2
Neurological and muscular	5
Disease of liver	1
Amputation	5
Arthritis	8
Total	129

The total patient days of care rendered at home to the 129 patients during the year was 25,444. The physicians made a total of 2509 home visits, which is an average of one visit every 10 days to each patient. Forty-two pa-

Hospital therapists also make home visits when the doctors prescribe them. Here, occupational therapist is starting a patient on a leatherwork project.

tients had to be hospitalized for varying periods during the year, and these patients spent an aggregate of 1165 days in the hospital. This is only 4.5 per cent of the total days' care.

Approximately one-third of the patients were male (44) and two-thirds female (85). Of significance is their age distribution. As shown in the following table, one-half were 70 years of age or older.

Age	*No. of Patients*
Under 30	3
30-39	5
40-49	9
50-59	12
60-69	35
70-84	60
85 and over	5
Total	129

Fifty-five patients were assisted by the Visiting Nurses Association, and 32 received housekeeping services.

FINANCES

The total cost of the program in 1952 was $21,762.28. Expenses were broken down as follows:

Expense	
Physicians' fees	$10,070.00
Other salaries	5,205.69
Drugs	4,996.72
Supplies	1,489.87
Total	$21,762.28

Public welfare and relief agencies reimbursed us at the rate of $3 per physician's visit and for drugs at cost, in behalf of any of their clients taken care of on our home medical service. Of the total of 129 patients, 60 were such public agency clients. The remaining 69 patients were charged in accordance with their ability to pay, the rate ranging from zero to a theoretical maximum of $2 per physician's visit. Inasmuch as all of these patients were medically indigent, the income from this source was negligible. In fact, only 15 patients paid anything at all toward the cost of their care.

Income	
Directly from patients	$ 288.00
Public agencies	8,191.82
Subsidy from sponsoring private agencies	13,282.46
	$21,762.28

One interesting feature about the finances of the home medical service is the cost per day and per physician's visit as compared with hospital costs:

Comparative Costs—1952		
Total expense of home care program	$21,762.28	
Total patient days' care rendered	25,444	
Cost per patient day		$ 0.85
Total physicians' visits	2,509	
Cost per physician's visit		8.67
Per diem hospital cost		26.25

Geriatrics Is a General Problem

The Criterion Is Medical Need—Not Age

RAY E. BROWN
Superintendent, University of Chicago Clinics

HOSPITAL facilities for the aging is a topic that to the average hospital administrator has a good deal in common with Mark Twain's comment on the weather—"Everyone talks about the weather but no one does anything about it." Unfortunately for the community at large, as well as for the hospital administrator, the problem of hospitalization for the aging cannot be shrugged off with the comforting knowledge that a solution is just around the corner.

The dramatic victories of medicine over bacteria-related diseases have in a single century increased the average life expectancy at birth from under 38 years to 68 years. The increase was from 49 to 68 years between 1901 and 1950. Already, one out of each dozen of our population has reached 65 years of age and the total is increasing at the rate of 400,000 a year. The country's population of individuals 65 or older went up 36 per cent between 1940 and 1950. By eliminating most of the environmental disease hazards, medicine has accentuated the much more difficult problems of degenerative diseases, both organic and functional. The medical advances in this field have been relatively slight. Actually, the life expectancy of those reaching age 65 is not significantly longer today than was that of the 65 year olds in the time of Napolean, or even of those in the time of Caesar.

Many factors complicate the hospitalization of the aging. Most of their illnesses are associated with the degenerative diseases and consequently most are chronic and long term. Because the duration is long the financial burden is great. The chronic nature of the illness means, in most instances, a complete loss of earning power to individuals who were already at a serious competitive disadvantage because of age. More than 32 per cent of persons over 65 years of age in this country live in households with a total annual income of less than $2000. In 1950, 43 per cent of the families headed by a person 65 years of age or older had a cash income of less than $1500. At the end of 1951, fewer than one in every three persons 65 years and older were receiving income from employment either as an earner or spouse of an earner.

Modern conditions of living have further complicated the illness problems of the aging. The size of houses and apartments today provides no extra room in which a person can be sick at home. The small size of modern families does not provide the extra pair of hands for home nursing that existed in most households a few generations ago. The odds are not too unequal that any able-bodied younger woman in the family will be busy at a job away from home. This same factor of job opportunities for women in industry has almost eliminated the supply of domestic help while pricing those still available out of reach of most families struck by chronic illness. It is within the framework of these complications that the patient, the doctor, and the hospital must attempt to meet the hospitalization needs of the aging.

The hospitalization needs of the aging can be classified into three types: (1) acute, definitive treatment; (2) continuing definitive treatment but of a rehabilitative and convalescent nature, and (3) custodial care of those patients whose condition has reached a static stage and who are largely bedfast.

It is the first group which, under our existing organization of medical facilities, is the primary concern of hospitals. The care of the second and third groups is at present considered by most hospitals the function of nursing homes. There is no medical reason why this has been true. General hospitals have separated the care of the short-term patient from the care of the long-term patient, and while they have moved heaven and earth to meet fully the needs of the short-term patient, they have moved about the same amount of real estate in their efforts to remain aloof from the needs of the long-term patient. We shall examine later some of the reasons general hospitals have been so reluctant to take on the problem of the long-term patient.

The hospitalization of individuals over 65 years of age who require acute treatment does not present a special problem to the doctor and the hospital. The same facilities of the general hospital are required as are needed in the case of other adults suffering from acute illnesses. The aging patient should be admitted to the same nursing units as are other adults undergoing similar treatment. Nothing is gained for either the hospital or the patients by segregating the aging during the period of acute treatment. I

question the current movement toward developing geriatics as a specialized branch of medicine. The enormous complexity of modern medicine has forced specialization according to system and structure of the body. The degenerative diseases emphasize that need for specialized knowledge. The creation of a horizontal and generalized branch of medicine cutting across the several medical specialties is a contradiction of the way medicine is taught and practiced. While I do share to some extent the concern currently being expressed over the fragmentation of medical practice I am reluctant to believe that the remedy lies in slicing horizontally instead of vertically.

The hospitalization of the aging person during the period of acute treatment does require one important component of hospital care that many of our general hospitals lack entirely. The medical social worker best demonstrates her rôle as a member of the medical team in the treatment of the aging. The success of the medical treatment of the aging patient depends a great deal on the proper interpretation of the diagnosis to the patient and his family, on obtaining their understanding and acceptance of the prognosis, and on helping them plan with the doctor for the subsequent care of the patient. This must be done during the period of diagnosis and acute treatment if it is to be done properly. It must also be done for all patients irrespective of their financial situation. Medical social work is not a service specifically for the indigent—it is a part of the medical service and should be utilized according to the medical rather than the financial need.

In the main we can say the short-term acute illness of the aging can be adequately treated in general hospitals. The unsolved problem is the provision of adequate facilities for long-term care. In my earlier classification I separated the long-term patients into two groups: those requiring continued medical attention because their condition indicates that further progress may be obtained; and those whose condition has reached a static stage and who are largely bedfast. The first of these two groups should be the responsibility of the general hospital. I am not too certain about the second group. If we use the simple principle that hospitals are medical care institutions it could be argued that the second group is not a primary responsibility of the general hospital.

There are many obvious reasons why general hospitals should accept the responsibility for hospitalization of the long-term patient who requires continuing medical and nursing care. Almost all the diagnostic and therapeutic equipment is already congregated in the general hospital. It would be wasteful for the community to attempt to duplicate that equipment whereas using it for both acute and chronic cases in the same hospital would lower the cost per unit through better utilization of highly trained and expensive technical personnel. Most important, general hospitals have medical staffs organized to provide medical care and to maintain the quality of that care. No better assurance of gaining for the long-term patients the best professional care a community has to offer can be made than to bring those patients within the orbit of the general hospital. Neither could any better plan be provided for assuring the maximum interest in research and education related to the long-term illnesses.

The location of the long-term patient in the same building in which the doctor makes his daily rounds would represent a great convenience to the doctor. It would also provide for integration and continuity of treatment through transfer of patients between the acute and the long-term sections of the hospital. The fact that the long-term patient was in the hospital environment where positive treatment is stressed would have a wholesome effect on the morale of the patient and his family.

(*Continued on Page 60*)

Integration Calls for New Yardsticks

JOHN D. THOMPSON
Assistant Director, Montefiore Hospital, New York City

THE problem of adequate hospital care of the aged is not a simple one; it cannot be solved by the mere formal establishment of a "geriatric division." Each department and clinical division of the entire hospital must be augmented and oriented to meet medical and social problems of the aged.

Let us briefly review the most important components of a true general hospital which will be particularly involved in providing not only hospitalization but a program of medical care for the aged patient. In order to do this, it is almost necessary to redefine the term "general hospital" inasmuch as many words in common use for some time have changed their meaning so imperceptibly that we tradition-bound human beings are not aware of it. Our conception of a general hospital is not a new one nor is it an invention of any place, time or person. It is the present status of a historical evolution of a living social organism responding to the stimuli of the community which it serves. The old "physicians' workshop" or "hotel for sick people" concept is as passé as Bedlam and the Pest House. This new general hospital is not an edifice, an end to itself, standing in magnificent or awesome isolation; it is an integral part of a community. The elements which compose this hospital, in addition to the usual inpatient facilities and outpatient clinics, are the departments of home care, rehabilitation, and preventive clinics. With such a plexus of service the general hospital is able to extend its medical care to all patients with all types of diseases and to all age groups. This is truly a general hospital.

Deliberately narrowing this frame of reference to the care of a specific age group with what predominantly

(*Continued on Page 60*)

Condensed from a paper presented before the second International Gerontological Congress, St. Louis, 1953.

The Criterion Is Medical Need—Not Age

(*Continued From Page 59*)

If the advantages of providing care for the long-term patient in the general hospital are so great, then why have most general hospitals so carefully avoided such arrangements? Several important factors have inhibited such a development. To begin with, the medical staffs have not demanded that hospitals furnish facilities for the long-term patient. Some of this reluctance on the part of the doctors can be explained by their sympathy for the financial problems already faced by hospitals. Too, doctors have not until recently appreciated the additional margin of salvage made possible by continuing the care of the patient through the period of long-term illness and the net profit to the patient in terms of reduction of the disability resulting from degenerative disease that can be obtained through medical care aimed at rehabilitation and preservation. For these same reasons the public has shown scant interest in demanding equal facilities for the long-term patient. The accomplishments in the treatment of the acute illnesses have been so rapid and dramatic that they have overshadowed the more difficult and less certain gains to be obtained from adequate treatment of the long-term patient.

Hospital trustees and administrators have doubtless been the most repressive influence of all. Their coolness toward the idea of involving the general hospital in the problems of the long-term patient has not been owing to their failure to recognize the problem. Every general hospital is faced daily with the problem of persuading relatives to remove such patients from the hospital. Despite these efforts, it is safe to say that long-term patients occupy more than 15 per cent of the bed capacity staffed for acute patients.

General hospital trustees and administrators have shied away from the responsibility of providing care for the long-term patient because of the diffi-

Integration Calls for New Yardsticks

(*Continued From Page 59*)

will be a group of long-term illnesses, let us examine some of these hospital services in the light of medical care for this older age group. I would first like to develop the importance of home care in a geriatric medical care program. At Montefiore Hospital, New York City, this program was most successful in treating patients on two clinical services—the medical service and neoplastic service. The percentage of hospital inpatients over 50 on these services was 67.9 per cent and 78 per cent respectively. During a two and one-half year study period the median age of the neoplastic patient on home care was 58, the median age of the medical patient was 60. Seventy per cent of all medical patients on home care were over 50, and 75 per cent of neoplastic patients were over 50. Of all home care patients 6.3 per cent were 75 or over. Although the total of 347 patients studied on home care is an admittedly small sample, there is evidence that elderly patients can be just as successfully maintained in the home as younger ones.

Walnut paneled lounge of the new John E. Andrus Home for Elderly People, Hastings-on-Hudson, N.Y., illustrates the kind of surroundings of which elderly patients dream and seldom see. Included in the home (but not shown) is an infirmary comprising three wards, private rooms, dining room and kitchen, doctor's offices, treatment room and laboratory.

It is necessary to point up here that the Montefiore home care program consisted of the integrated use of the "hospital team" in the home, including the doctor, social worker, visiting nurse, occupational therapist, and

cult financial problem involved. I mentioned earlier the bleak personal financial situation that characterizes the aging person in our population. The financial situation is infinitely worse when that person is felled by long-term illness. Whatever employment he might have had is now terminated. He enters the long-term stage of his illness in most instances after a financially exhausting siege of acute illness. Rarely will he have hospitalization insurance. This is true because the manner in which such insurance is marketed has stacked the cards against him. Most of the acceptable hospitalization insurance available in this country is sold on a group basis and on a pay-roll deduction plan. The aging person is least likely to have a job and a pay check from which to deduct. Much of the insurance written automatically bars persons over 65 years of age even though they have funds to carry the cost of coverage, or else the differential in rates imposed on those who retire from the employed group is so great as fully to discourage individual payments. Almost universally, the number of days of hospitalization benefits provided in insurance contracts is so set as to cover only the period of treatment usually required for acute illnesses. Such discrimination by Blue Cross and commercial hospitalization insurance underwriters is regrettable but necessary if they are to remain solvent. The prohibitive costs involved preclude the underwriting of the expense of long-term illness by prepayment insurance programs.

The general hospital, however, cannot afford to undertake the care of the long-term patient without full assurances of reimbursement. Our voluntary hospital system is almost entirely supported by patient income, including payments by third parties. Who is to do the paying is fairly obvious. If the average patient cannot pay, either directly or from prepayments made to insurance programs, society in general must pay. Donations by society in amounts of any consequence to the problem are out of the question. The answer lies in taxation in some form and at some level of government competent to produce the funds necessary to cover full costs of care for the long-term patient. It should be pointed out here that such payments will have to cover a reasonable professional fee for the doctor as well as the payment of the hospital bill. The medical staffs of hospitals simply cannot be expected to add the burden of free medical care for the long-term patient to their existing load of charity work in the hospital.

(*Continued on Page* 150)

physical therapist, as well as housekeeping aid, medical equipment and ambulance service at a cost of just below $3.50 a day. This excellent medical care was given in an evironment much less foreign and traumatic to the patients' sensibilities than the hospital ward. Patients were accepted on home care before actual admission to the hospital as well as after medical indications for hospitalization ceased to exist. It is difficult to visualize any real health program for the care of the aged without home care. The hospital team coverage must be extended to include such substitutes for the home as homes for the aged, true convalescent homes, and custodial institutions, all under the social and medical supervision of a general hospital.

The part of hospital care which actually takes place inside the walls of the institution, *i.e.* inpatient care and the preventive and therapeutic clinics, must be cut to fit one to the other and both to the pattern of home care. There must be free passage of the patient from the outpatient department to home care and inpatient facilities. One condition for the successful operation of any home care program is the guarantee that a hospital bed will be available should the medical condition of the patient so change that he needs inpatient care. Likewise, if an elderly patient can no longer attend the outpatient department, this is no indication for hospitalization since he may very well be transferred to home care until inpatient care is indicated.

Integration is seldom obtained by a spontaneous action of independent—even though closely related—services. There has to be a unifying factor, a common denominator as it were, to weld these various services into a team and focus the energies and skills of the team on one individual—the patient. In our hospital, the division

(*Continued on Page* 152)

From circular, modern desk in the center of the cross formed by the four wings, an attendant commands a view of each of the four corridors from which guest rooms are entered in the John E. Andrus Memorial Home.

A.M.A. Makes New Doctor-Hospital Statements

House of delegates takes new look at salaried service, condemns insurance contract including medical services

IN A series of reports and resolutions, the house of delegates of the American Medical Association, meeting last month at St. Louis, took up several different positions involving the difficult question of hospital-physician relations and, especially, the standing of the salaried physician. In separate actions, the house of delegates:

1. Approved a reference committee report asserting that the joint A.M.A.-A.H.A. statement on hospital-physician relationships adopted by both groups last summer "is supplemental to but does not replace or repeal" the earlier "Guides for Conduct of Physicians in Relationships With Institutions."

2. Approved the report of another reference committee including an interpretation by the Judicial Council holding that "the acceptance of a salary by a physician does not necessarily constitute unethical conduct. . . . The Council does not believe that a financial arrangement, whether by salary or otherwise, between a physician and a hospital, can be appraised or evaluated and found to be ethical or unethical until all the facts are established."

3. Passed a separate resolution condemning the hospitalization insurance contract written for employes of Swift & Company by Health Service, Inc., the Blue Cross insurance company, for its "disregard of the principles as set forth by the house of delegates of the American Medical Association, which principles define pathology, radiology, anesthesiology and physiatry as medical services."

As the smoke cleared, it was hard to tell just what these actions meant and what effects they might have. Some observers, for example, pointed to the action specifying that the joint A.M.A.-A.H.A. statement on hospital-physician relations supplemented but did not replace or repeal the earlier "Guides" as indicating the A.M.A. opposes the disposition of professional services of a physician to a hospital "under terms or conditions which permit sale of the services of that physician by such agency for a fee," as stated in the "Guides."

As approved by the A.M.A. house of delegates last June and the A.H.A. delegates at San Francisco in September, the joint A.M.A.-A.H.A. statement specifies only that a physician must not dispose of his professional services to a hospital "under terms or conditions which permit exploitation of the patient, the hospital, or the physician." Many hospital people have interpreted the difference between this language and that of the "Guides" as an indication of changing policy. Taken together, however, the two statements have appeared to others to mean that "exploitation" exists whenever the hospital is billing and collecting for or "selling," the physician's services. This meaning is now strengthened, it is argued, by the new action asserting that the joint statement supplements but does not replace or repeal the "Guides." However, A.M.A. representatives have said, both the "Guides" and the joint A.M.A.-A.H.A. reports were explanatory rather than policy-making statements; A.M.A. policy is expressed only in the Principles of Medical Ethics, which stipulate that a physician must not dispose of his services under terms or conditions "which permit exploitation of the services of the physician for the financial profit of the agency concerned."

Whether or not exploitation for profit exists must be determined by a specific finding of fact in each individual case, the A.M.A. Judicial Council has ruled. "The Council has repeatedly stated its opinion that the acceptance of a salary by a physician does not necessarily constitute unethical conduct," the Council said in the report approved by delegates at St. Louis. "The issue to be resolved is factual. . . . If in a given situation a doctor disposes of his professional attainments or services under terms which permit exploitation of those attainments or services by a hospital, then he violates a principle of medical ethics. . . . The Judicial Council does not believe that a financial arrangement, whether by salary or otherwise, between a physician and a hospital, can be appraised or evaluated and found to be ethical or unethical until all the facts are established. The Judicial Council believes that the 'Guides for Conduct of Physicians in Relationships With Institutions' and the 'Report of the Joint Committee on Hospital-Physician Relationships of the A.M.A. and A.H.A.' make it abundantly clear that questions which arise under . . . the Principles of Medical Ethics depend for their solution upon an analysis of the factual situation which obtains in each relationship."

Plainly indicating that the A.M.A. does not regard salaried service as

(*Continued on Page* 170)

Above: Aerial view of the new Children's Orthopedic Hospital, Seattle, built at a total cost of $4,549,852.62. Right: This adaptation of the hospital's emblem, the Della Robbia Bambino, was created by Jean Johanson of Seattle.

Children's Hospital Is True to Its Tradition

THE MODERN HOSPITAL OF THE MONTH

The new hospital offers the best in medical care while creating a joyful spirit of play for the children

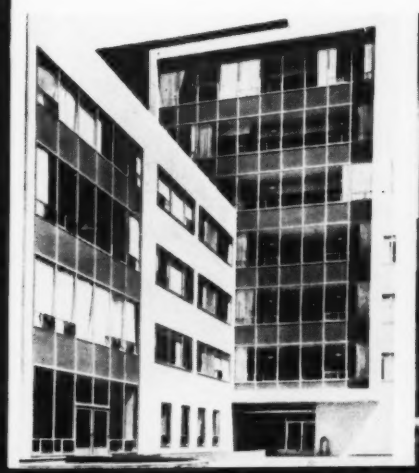
JANET WATSON BRADY
Public Relations Director
Children's Orthopedic Hospital, Seattle

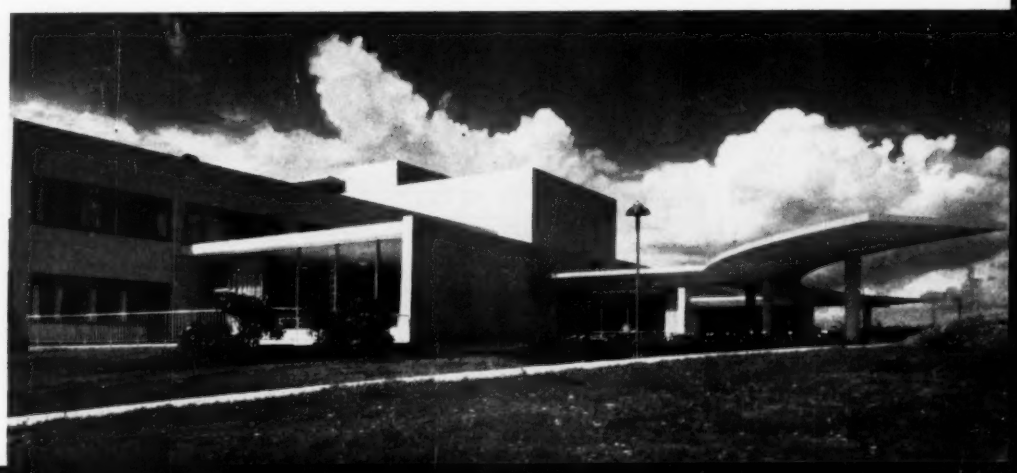
THE Children's Orthopedic Hospital, Seattle, having become inadequate for the tremendous increase in patients, required a new location which would make possible increased facilities. The original hospital, established in 1907, was built on Queen Anne Hill, and had been enlarged from time to time to accommodate approximately 135 beds.

From the beginning of orthopedic work, the functions of the hospital over its 46 year history were broadened to include a variety of services generally found in child health centers. The location of the old hospital on Queen Anne Hill did not permit further economical expansion. Looking far into the future, the hospital board obtained a 25 acre hilltop site in Laurelhurst, a residential district near the University of Washington.

A unique tradition has grown up around the hospital, *i.e.* the idea of caring for children by bringing to bear all the latest tested innovations that medical science offers and at the same time overcoming the fearful aspects of hospitals by creating a joyful spirit of play. For example, the difficult task of child dentistry becomes a high spot of the day with the traveling dentist bringing to the hospital bed his wonderful, mysterious implements much like a character out of a new Mother Goose. Again, the terrible business of putting a child to sleep under anesthesia has been mitigated by the installation of a "Peter Rabbit Room" wherein the children, without seeing any medical paraphernalia, are put to sleep in a beautiful toyland. Countless other ideas have been established to lend interest and charm to the patients' stay at the hospital. As the program for the new hospital was developed, these time-tested therapeutic processes were carried forward and

Left: Close-up of one facade of the hospital shows the smooth-surfaced wall composed of aluminum honeycomb core panels with porcelain face. Right: A southeast view of the entrance shows the picture windows used in both the outpatient reception room at left center and the main lobby at right center.





Alice in Wonderland, Snow White and Peter Pan all smile a friendly "hello" from the colorful mural in the outpatient lobby designed by John S. Detlie.

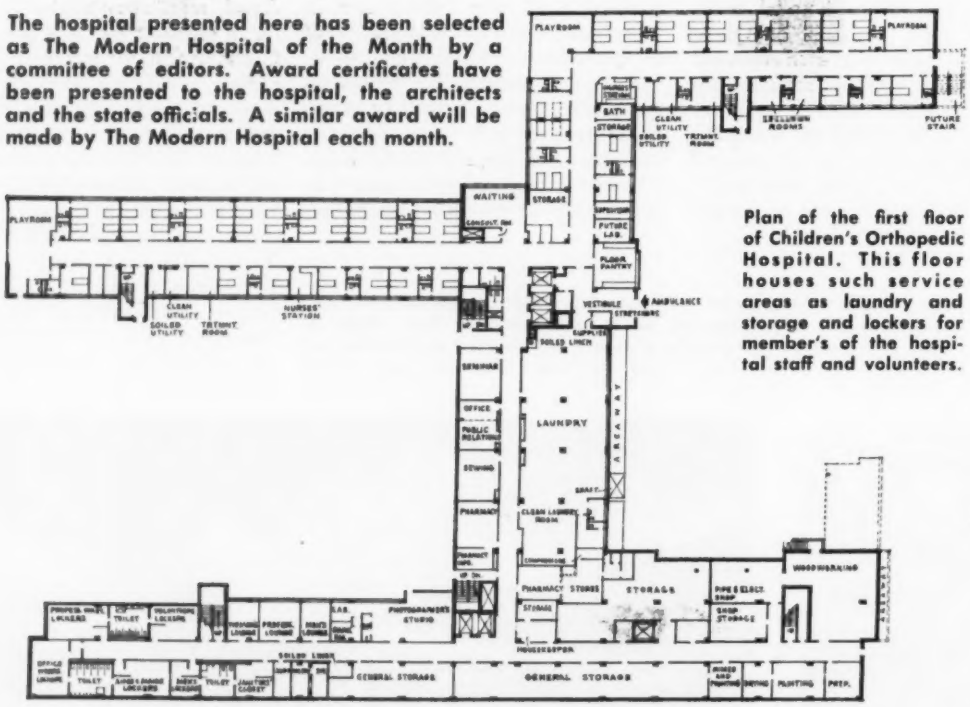
became a part of the design criteria for the new building.

To accomplish the new hospital, the board of the Children's Orthopedic Hospital employed Young and Richardson, Carleton and Detlie, architects, of Seattle. Schmidt, Garden and Erikson of Chicago, consulting architects, and Dr. Herman Smith of Chicago were retained as consultants. The expanded program was drawn for an ideal children's hospital with complete expansion for all future needs. The 25 acres chosen as the site for the new development were located in a residential district overlooking Lake Washington and the Olympic Mountains. The hilltop site, generally, slopes to the west with the more level part on the top to the east.

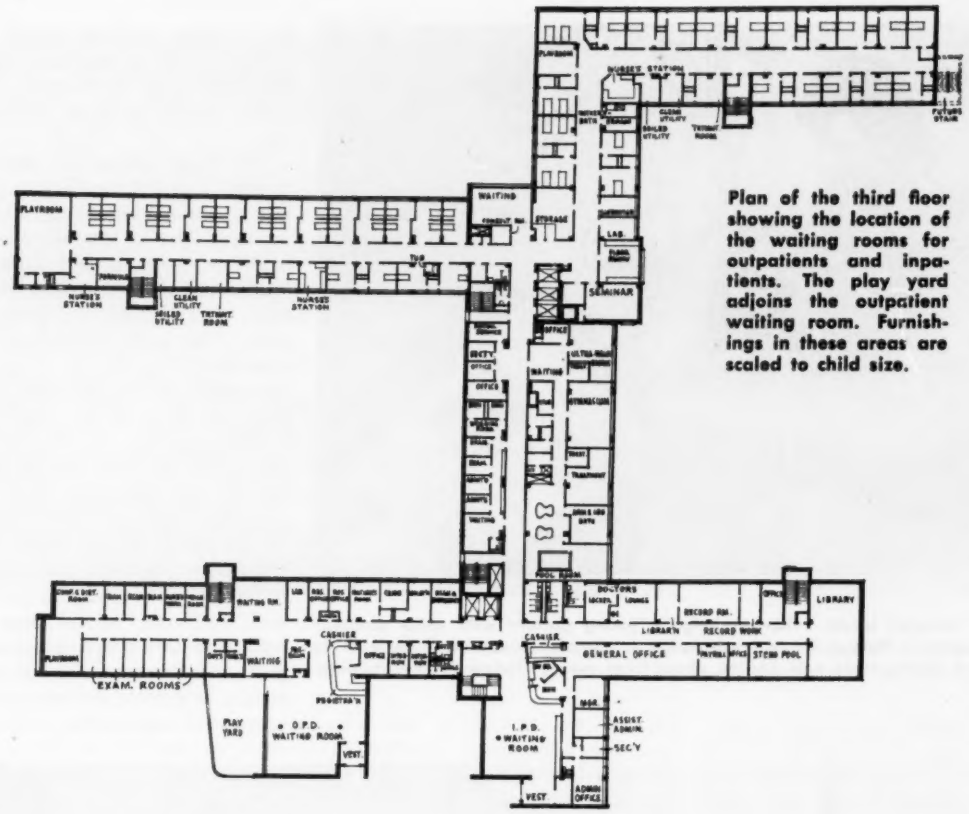
This large tract in the residential heart of a rapidly expanding city afforded an ideal area for the future development of a complete child center. The position of the hospital on the main forward slope and to the southeast gives ample room for a logical and orderly development for additional facilities such as a nurses' home, special therapeutic buildings, orthopedic guild center building, expanded heat and power plant, and perhaps a doctors' clinic for private patients. Inasmuch as the building is located on the north-south arterial Sand Point Way, it was possible to use this highway as a main access to the site without entering the residential district.

A successful hospital must not only house many complicated therapeutic and administrative functions but must impart a sense of well-being to the patients. At the same time the whole building must be designed for efficiency and economy. Both the therapeutic and administrative processes involved in modern medicine and hospital operation are constantly changing. Consequently, one of the principles of design in the building was to incorporate in its structure and partitioning of space as much flexibility as possible by the use of a modular structural forming system and a mod-

The hospital presented here has been selected as The Modern Hospital of the Month by a committee of editors. Award certificates have been presented to the hospital, the architects and the state officials. A similar award will be made by The Modern Hospital each month.

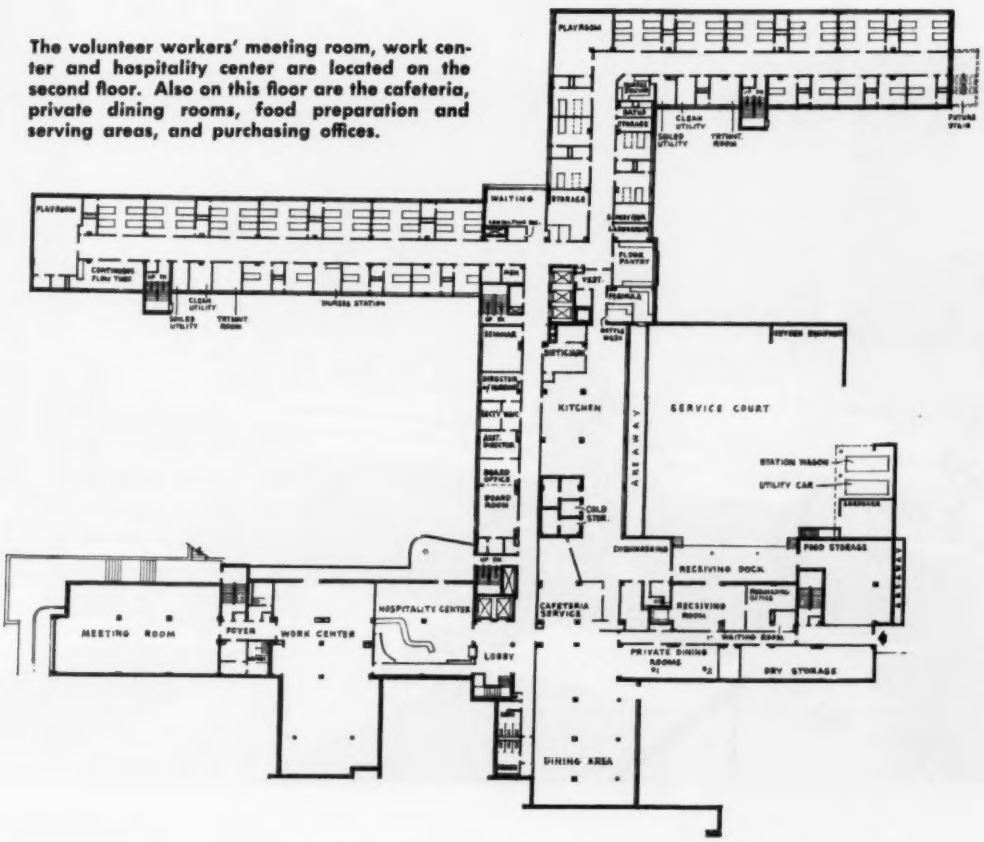


Plan of the first floor of Children's Orthopedic Hospital. This floor houses such service areas as laundry and storage and lockers for member's of the hospital staff and volunteers.



Plan of the third floor showing the location of the waiting rooms for outpatients and inpatients. The play yard adjoins the outpatient waiting room. Furnishings in these areas are scaled to child size.

The volunteer workers' meeting room, work center and hospitality center are located on the second floor. Also on this floor are the cafeteria, private dining rooms, food preparation and serving areas, and purchasing offices.

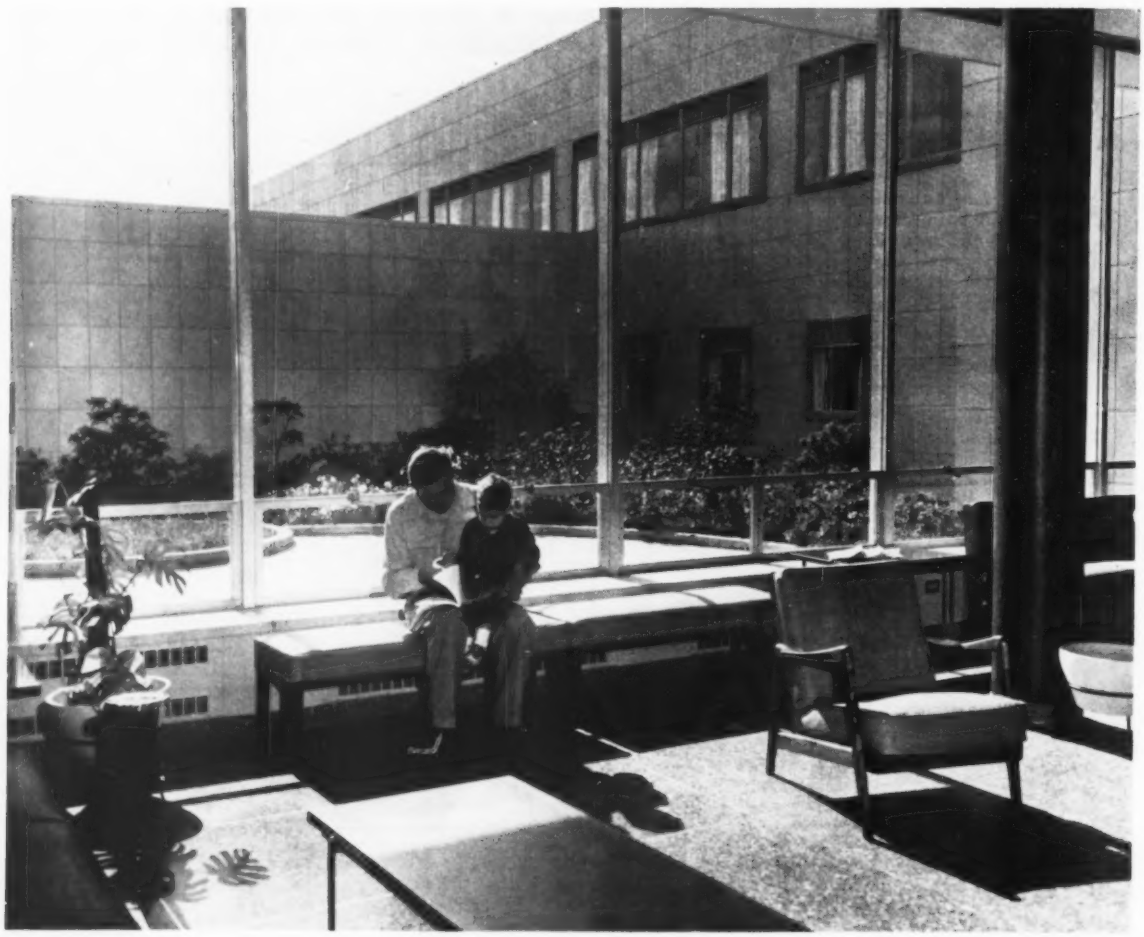


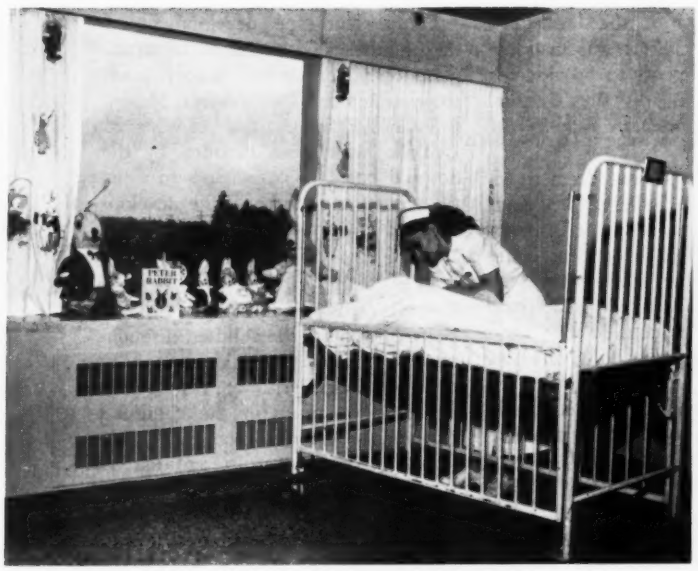
Above: A hospital junior volunteer helps a young patient with some amateur clay "sculpture." Below: When landscaping is completed, one will be able to see sloping lawns, trees and garden areas from every window in the building.

ular window mullion system, which would provide for easy rearrangement of interior spaces by changing the partitions on the modular mullion system.

The large outpatient service demanded a special handling in its relation to the central service. Owing to the large span of time often involved in the treatment of child health problems, inpatients come back again and again after dismissal for future treatment. This adds to the load on the outpatient department. Virtually all the central service, therefore, must be readily available to the outpatients.

Some aspects of the Children's Orthopedic Hospital are, in a sense, unique. The activating force behind this institution is extraordinary both for its extent and for its enthusiasm. Virtually, the entire female population of the state of Washington and Alaska, with additional support from neighboring western states, is organized in guilds which engage in countless activities to provide the institution with operational and building funds. In ad-





Left: The "Peter Rabbit" anesthesia rooms are designed to divert patients from fear of surgery. Right: Two visitors inspect one of the airy playrooms.

dition, the general public enthusiastically supports the whole activity. With the entire operation thus built on the voluntary donation of time, money and skill, part of the hospital building must naturally house the activities of volunteers engaged in such tasks as teaching, occupational therapy and rehabilitation.

Furthermore, the utilization of the voluntary services of physicians and surgeons necessitates the kind of facilities that will call forth their best and most enthusiastic efforts. In return for their time and skill, a congenial environment was mandatory. The whole Children's Orthopedic Hospital is to be thought of not as an institution but as the favorite activity of a host of people, which it is. Therefore, making the public feel at home in the hospital which it has created is the best insurance that this creation will continue to thrive.

BUILDING CONSTRUCTION

The general criterion was established that the structure should be completely safe, fireproof, able to withstand major seismic forces, expandable, easy of maintenance, economical and attractive. The building is a reinforced concrete structure with room for the addition of nursing units above the present nursing wings, the fourth floor outpatient space, and the expansion of some functions within space presently used for storage. Underground tunnels leading from the present structure to future facilities have been provided for by the placement of waterproof joints at those levels.

Finishes throughout the hospital, both exterior and interior, were selected for practicality and economy and, at the same time, with an eye for their relation one to another so that a beautiful effect would result. The exterior concrete structure has been clothed in permanent colored ceramic veneer in contrast with the stair and elevator towers and retaining walls, which are oversized Roman brick of rich texture. In general, interior finishes have been selected to provide resistance to wear. All finishes, both exterior and interior, were selected after due consideration of initial cost on the one hand and maintenance cost on the other.

The establishment of a proper atmosphere for the building was a special consideration in the design of Children's Orthopedic Hospital. Each separate phase of the over-all problem posed its particular difficulty. The questions of scale, color, landscaping and details, all had to be solved with the general purpose of giving the physical appearance of the hospital less of an institutional aspect and more of the characteristics of a place that would delight and charm the little patients into a sense of well-being.

The problem of scale was difficult. Two-hundred bed hospitals have a way of looking huge because the nursing units contain a series of four-bed wards, with the necessary auxiliary administrative and treatment rooms. The central service and adjunct facilities placed one above the other for economy naturally presented a considerable mass. The other administrative and outpatient wings stretching above made a sprawling structure. For economic reasons it was efficient to use structural modules of bay spacing and modules of fenestration, yet the effect inevitably suggests an institution. To combat these natural tendencies toward overwhelming hugeness and monotonous repetition, every possible scale-reducing device was employed.

From the exterior the extent of the wings was reduced by using the ceramic veneer and Roman brick, thereby playing the contrasts between these materials as a method of reducing the extent of the masses. The entire entrance motif from the eastern approach was designed with a feeling for small scale to establish a sense of intimacy at the first point of contact with the hospital by the child patients. Elsewhere, about the exterior, particularly in the handling of the patios and gardens, attempts were made to provide many "surprises" of low, small-scale, intimate features that are well within the child's vision as a counterfoil to the rather overpowering building. The hospital itself in that sense is used as a background. For reasons of economy, some of these scale-reducing elements have been left for future accomplishment.

On the interior, from the point of entrance throughout the hospital wher-

ever the rooms are for the use of children, child-size scale prevails. Ceilings are low. Rooms are ample but intimate. The design of spaces primarily for the children's use, such as playrooms and waiting rooms, was conceived from an eye level of 3½ feet, and everything decorative was tested against the criterion of the right size for children.

COLOR

Color was treated as a positive element in the over-all design of the hospital, and special recognition was given to the fact that with the proper use of color additional therapeutic possibilities could be realized. On the exterior, the ceramic veneer selected is a warm bisque color and its tones are further enriched and intensified in the buffs, salmon and burnt orange of the Roman brick. Against the well established warmth, a cool fresh blue has been used as a painted trim color for the metal windows. Spandrels between the playrooms and the waiting rooms are painted the same blue hue but deepened and intensified. Basically, the warm toned building with its cool counterpoint was selected because it would afford a superb contrast with the green plant material to be installed. Some minor color notes on the exterior—maroon, gray and white—were employed to aid in reducing scale.

On the interior, color was even more important. First, a system of pleasantly varied and contrasting avenues in the corridors, elevators and other thoroughfares was created, beginning with a restatement in the various entrance lobbies of the exterior colors. From these exterior colors, variations and harmony have been created which lead from wing to wing and give access to individual rooms, wards, work areas, and office suites, each of which has been treated as further variations on and in contrast to the particular corridor color harmony. Generally, the most exhilarating harmonies are employed in those rooms in which people are to remain for a short time and engage in stimulating activity, and the more soothing and restful color harmonies are reserved for residential and therapeutic areas to yield a quieter environment.

LANDSCAPING

Of particular concern in the handling of the whole hospital design was the organization of the landscape treatment. Every effort was made in planning the elements to provide for the beautification of the hospital grounds both presently and in the future.

At the outset it was deemed advisable to set the building well back from the existing residential streets. It also became obvious that access to the site by the public should be from Sand Point Way. A grade could be utilized that is considerably lower than the steep existing hills; this low gradient access road would be less hazardous during icy winter conditions and easier to negotiate on entering the hospital property from city thoroughfares than would any present road. Too, the approach from Sand Point Way would yield a rich visual experience to the visitor, and would become a main stem from which minor access could be had to future developments on the north portion of the property.

At present, various parking areas have been provided, with secondary roads leading to the service court and ambulance entrance. In contrast to the rich curves created by the main road, the rectilinear areas formed by the geometry of the projecting wings of the hospital form the beginning point of the interesting landscape treatment. Because the hospital is on the slope of the hill and steps down four floors, retaining walls surfaced with Roman brick have been provided, extending the lines of the hospital building into the landscape as each level breaks down to a lower level in step fashion. The curvilinear lines of planting beds, minor retaining walls, promenades and paths carry out the main curve established by the entrance road and serve to bring a sense of intimacy into the local gardens.

Ambulatory patients have access to many courtyards, including the entrance courtyard, the south sun court (which will be used for the annual circus festival), the south play court, the chapel court, the occupational therapy garden, the north play court, and adjacent eastern play court, ambulance entrance court, service court, dining terrace and courtyard. Of particular interest in the landscape problem was the placing of four live Christmas trees so located on the hospital grounds that from any window at least one tree can be seen by patients.

Future landscape development of the premises was the subject of an intense open competition among landscape architects. The winners, Messrs. Cash M. Beardsley and Charles A. DeTurk, have been retained by the hospital board as consultants to assist the garden committee in the development of a complete landscaped site.

PAINTING AND SCULPTURE

Additional points of interest specially created for the children throughout the hospital are paintings, sculpture and allied arts. It was deemed advisable to create in the children's outpatient waiting room a warm, friendly atmosphere. In addition to the toy-like quality of the decorating and furnishings of this room, a large mural was designed by John S. Detlie, and executed by Jacobson and Grund, painters and decorators, to provide a focal point which would hold the interest of the waiting children and lessen the hectic atmosphere of a roomful of ailing children. It is anticipated that the montage of innumerable fairy tales will hold their imagination for a time. Additional murals are planned for each individual playroom.

Sculptures are planned for several focal points. Of those completed, the Bambino symbol at the entrance to the inpatient department is noteworthy. This polychrome circular medallion was made by Mrs. Jean Johanson. In addition, Mrs. Johanson has created works of art in the chapel on the ground floor, working in plaster for the angels above the altar and in bronze for her series of eight plaques depicting the story of creation with child-like elements. Further to enrich the chapel and again to provide an atmosphere that will particularly appeal to the children, stained glass windows depicting the stories of the Ark, Moses, the Nativity, and the Resurrection were designed by Mr. Detlie and executed by Anton G. Rez, both of Seattle.

To complete the proper environment throughout, furnishings were selected that are practical and economical. Forms and colors used in the seats, sofas, storage cabinets, and decorative elements generally capture the eye of the children and create a joyful atmosphere. In areas used by the public and by hospital personnel the furnishings were chosen on the basis of practicability, cost, ease of maintenance, and to further the color scheme chosen for the hospital.

Staff Membership Is Decided by the Hospital

Court rules doctor has no "inherent right" to practice in a private hospital unless the hospital agrees

LEE O. GARBER

Associate Professor of Education
School of Education, University of Pennsylvania, Philadelphia

A PRIVATE nonprofit corporation that owns and operates a hospital has the right to grant to or withhold from any licensed physician or surgeon permission to practice in such hospital, according to a recent case decided by the Supreme Court of Florida.* Likewise, while the question was not before the court for decision, it stated by way of *dicta* that a physician has no inherent right to practice in a public hospital—that the opportunity to practice therein is a privilege rather than a right. In this case the court also differentiated between public and private hospitals. It held that while a private hospital may be conducted as a public charity, and may receive appropriations from governmental units, it does not, thereby, lose its status as a private hospital. The real test of its status is found in its ownership and management. If owned by a private corporation and if no governmental unit has the authority to dictate terms for its management or control, the hospital is considered to be a private rather than a public hospital.

PRIVILEGE WAS WITHDRAWN

In this case a physician, licensed to practice medicine and surgery in the state of Florida, brought an action against the West Coast Hospital Association to enjoin it from interfering with his use of the hospital's facilities for performing major surgical operations upon his patients. At one time the physician had been granted a "probationary privilege" to perform surgical operations in the hospital under the supervision of some member of the surgical department. Later, this was withdrawn and he was no longer permitted to use the hospital's facilities.

He alleged that he was a resident of Clearwater, Fla., and that he was a member of the corporation that owned and operated the hospital, by virtue of having made contributions and pledges to its building fund. Likewise, he alleged that the hospital was a public, or at least a quasi-public, entity by virtue of the fact that it received contributions from the city of Clearwater, which had been raised by taxation, and from the county of Pinellas; that the public generally had contributed to it, and that the public relied upon it for services—it being the only hospital in the city and vicinity, and served some 35,000 persons.

Two important questions were before the court for decision. The first question was whether or not the corporation, in the operation of the hospital, was a private corporation, operating a private hospital not for profit, or a public corporation, operating a public hospital. The second question was whether the physician had a right to practice in the hospital.

The facts concerning the organization, management, operation and control of the hospital were not disputed. It was organized under the laws of Florida as a corporation not for profit. Its charter clearly set forth its purpose, the qualification of its members, and the method of its management by its own officers elected by the members. Evidence indicated that the annual contributions of the city of Clearwater, from taxpayers' money, amounted to approximately 1 per cent of the hospital's total annual operating revenue, and the amount contributed by the city for expansion amounted to about 1 per cent of the cost of expansion. The county of Pinellas had, on the other hand, made no gifts or donations, but had paid the bills for the treatment and care of indigent patients who were residents of the county.

NOT A PUBLIC INSTITUTION

In disposing of the question of whether the hospital was or was not a public hospital, the court said:

"Such contributions from the city of Clearwater, or the payment of bills by the county of Pinellas, or the contribution by the United Community Fund, or the voluntary contributions from the public generally, to a private nonprofit corporation for the purpose of enabling it to own, operate and improve a hospital, do not make such hospital a public institution.

"A private hospital may be conducted as a charity . . . . A private hospital may be supported by the state, the county or municipality, without becoming a public hospital . . . ."

The physician, however, contended that the court had, in the past, recognized the public character of a private corporation engaged in a business affected with a public interest. In this connection, the court said:

"It has long been the established law

*West Coast Hospital Association *v.* Hoare, 64 So. (2d) 293 (Fla.).

in this state that when a business is clothed with or affected with the public interest so that it affects the health, safety, morals, comfort and general welfare, such business is subject to reasonable regulation prescribed by the legislature. There is no contention here that the legislature has attempted in any manner to regulate the management, control and operation of a private hospital in determining who may and who may not be given the privilege of using the facilities of such hospital for the practice of his profession.

"Without determining the question, it may be that the legislature has the power and authority to regulate private hospitals, but it has not attempted to do so."

The court, after ruling that the hospital was a private one, considered the right of the physician to practice therein. It pointed out that a private hospital, like any private corporation, has the right to manage its own private affairs through the board or officers provided for in its charter—that such a hospital has the right to make rules governing patients and physicians and to conduct its business as it sees fit, as long as its acts are not fraudulent, illegal, beyond the scope of its authority, and are not negligently or otherwise wrongfully harmful to another. It cited authority to show that courts are in practically unanimous agreement in holding that a private hospital has the right to exclude licensed physicians from practicing therein. It then went beyond this and pointed out that a physician does not have a statutory or constitutional right to the unrestricted use of the facilities of a public hospital—that a public hospital may establish reasonable rules or regulations concerning the qualifications of physicians permitted to make use of its facilities. Quoting with approval from a previous case, *Green* v. *City of Petersburg*, 154 Fla. 339, 17 So. (2d) 518, it said: "When the city furnishes the facilities and takes the risk against their negligent use, it is not too much to require that he who wields the knife does so in the philosophy of the Twentieth rather than in that of the Eighteenth century."

The physician, however, contended that the fact he had made contributions and pledged additional contributions to the hospital not only made him a member but it gave "him some kind of a special right, or privilege, as a practicing surgeon to use the physical facilities of the hospital." The court refused this contention and ruled that membership gave to him no right to use the hospital's facilities.

Finally, the physician set forth in great detail his qualifications as a surgeon. The court held that in view of the fact it had ruled the hospital was a private one and not governed by the laws, rules and regulations in force as to public hospitals, the facts of his qualifications and experience were immaterial with respect to the question involved, and added: "The qualifications of a physician or surgeon may be perfect on paper, but such paper qualifications do not vest in him the right to practice in a private hospital should the managing authorities, in the exercise of their discretion, exclude him or refuse to grant him such right or privilege."

How Community Internships Worked Out

JACOB HOROWITZ, M.D.
Associate Manager
Department of Health and Hospitals
Denver

THE community rotating internship—a new concept in internships—was inaugurated at Denver General Hospital, Denver, in July 1952. This public hospital cares for the indigent and medically indigent of the city and county of Denver. Prior to 1952, the house staff consisted of 16 rotating interns and from 40 to 50 residents. In July 1952, 16 additional interns were selected for the community rotating internship program.*

During the first six months, eight of the community interns were assigned to the Denver General Hospital and eight to several selected private hospitals in Denver. During the second six months, those at Denver General went to the private hospitals and those at the private hospitals went to the Denver General. The following was the schedule of rotation:

Denver General Hospital

Pediatrics	1½ months
Medicine	1½ months
Orthopedics	1½ months
Emergency Room	1½ months

Private Hospitals

Surgery	3 months
Medicine	1½ months
Ob & Gyn	1½ months

The community interns were interviewed in the private hospitals at the end of their first three months and their first six months of service. The interviewing was done by two teams of physicians. Each team was made up of one doctor from a participating private hospital and one doctor from the administrative staff of Denver General. The schedule was so arranged that team members did not interview the community interns serving at their own hospital.

The general impression gained was that all the community interns were highly satisfied with their experience. When asked, "Would you make the same choice of internship if you had another chance?" 15 of the 16 interns replied in the affirmative.

The major criticisms voiced were:

1. Insufficient preoperative and postoperative experience. The interns on surgery in the private hospitals scrubbed every day and had little time for rounds with attending surgeons.
2. Often bypassed by nurses in carrying out orders left by the physician.
3. Lack of experience in gynecology, especially in the fundamentals of office gynecology.
4. Not called to see acute surgical cases on admission.

The following steps are being taken to meet the foregoing criticisms:

1. Schedules are being planned so that the interns assigned to surgery will scrub every other day. Thus, they can make rounds with the surgeons.
2. The attending physicians have been instructed to leave orders with the interns on their service.
3. Interns will be given time off to attend the gynecology clinics at Denver General and at Colorado General.
4. The attending physicians now call the interns to participate in examining and discussing acute surgical cases at the time of admission.

As a result of the foregoing experience, it was unanimously decided to continue the community internship for another year. If it continues to be a desirable program, it will be enlarged to include other participating hospitals.

*Horowitz, J.: The Community Rotating Internship. Mod. Hosp. **81**:100 (July) 1953.

Hospital Credit and Collections

A credit consultant offers solutions to the credit manager's worst problem: collecting after the patient has left the hospital

WALTER B. MORRISON
Credit Consultant
South Shore Hospital, South Weymouth, Mass.

COLLECTION procedures to be followed by the hospital after the patient has been discharged will be determined largely by the financial arrangements made at the time of discharge. An essential preliminary to a successful collection procedure is the obtaining of a complete credit and financial picture. If such information was not obtained at discharge the use of current credit reports is recommended on major accounts. Credit reports are also suggested as a current check on questionable information given by patients at discharge.

Recommended collection methods include: (1) correspondence, (2) telephone, (3) telegrams, (4) personal calls, (5) through referring doctors, and (6) small claims court—Massachusetts cases.

CORRESPONDENCE

Statements—use sparingly. There is no need to send statements each month where agreement was made regarding payment at discharge.

Use as initial contact with patients who were discharged with no agreement as to when and how hospital bill is to be paid.

Use as a reminder of on-account payments now due as promised.

Use on all accounts once or twice yearly at time of audit. Use auditor's stamp and return address.

Printed or duplicated forms are useful on small accounts but even here they are not as effective, usually, as an individually typewritten letter. Form sentences and form paragraphs may be used but will be more effective if letters are individually typewritten.

Many handbooks are available on the writing of effective collection letters. One of the most helpful is entitled "Psychology in Credit Letters" by Helen M. Sommers. The section that deals with collections is highly recommended.

Letters come under four general headings:

1. Reminder letters.
2. Discussion letters.
3. Appeal letters.
4. Final demand, or threat letters. (Never threaten unless you intend to follow through promptly.)

The frequency of collection correspondence depends on the public relations policy of the particular hospital. Where there are no known extenuating circumstances, and no answers to previous letters, it is suggested that no longer than two weeks be allowed to elapse between letters.

At this point it is strongly emphasized that each case is entirely different, individualistic. Acceptance of that fact, and individual and thoughtful attention to what is said and how it is said in collection letters will go a long way toward producing the desired result.

TELEPHONE

This is probably the most inexpensive and effective means of making personal contact, reaching an agreement, and eventually collecting. One is as close to the patient as it is possible to be except by a personal visit to the patient's home or place of business. Increased use of the telephone by competent collectors, in conjunction with correspondence, is strongly recommended.

Suggestions: Be sure you are talking to the person responsible for the hospital bill.

Be very careful when the telephone is in the name of a relative or a neighbor.

Leave a message to have the person you are trying to contact call you.

Leave your name and the number—*do not* mention the hospital.

Use extreme caution in contacting persons through their employers or places of employment.

TELEGRAMS

Telegrams are particularly effective on out-of-town and out-of-state cases. Use discretion in wording them.

This is the second of two articles on credit and collection procedures by Mr. Morrison. The first appeared in the December issue of this magazine. These articles were prepared in fulfillment of the requirements for the Executive Award and for graduation from the Graduate School of Credit and Financial Management, sponsored by the Credit Research Foundation, the National Association of Credit Men, the Amos Tuck School of Business Administration of Dartmouth College, and the Graduate School of Business of Stanford University, and conducted at the Tuck School, Dartmouth College.

The hospital's attorney might be asked to give legal approval to several collection messages, and the telegraph company has many suggestions to offer as to effective collection messages that have been used by others.

PERSONAL CALLS

The personal call offers an excellent opportunity for the collector to judge circumstances at the home level, but it is somewhat expensive unless the social service department is used for that purpose.

The collection policy as outlined by the administrator usually contains the promise that the referring doctor on private cases agrees to see to it that the hospital collects first, the doctor second. Getting in touch with the doctor, or the doctor's secretary, is therefore an important step early in the collection effort. Many times the doctor can, if he will, give valuable information and may be instrumental in effecting collection for the hospital. Should the collector find that certain doctors are ostensibly better collectors than the hospital, or that they get paid in advance, such facts should be conveyed to the administrator in a report.

SMALL CLAIMS COURTS

On cases involving less than $50, small claims action is extremely effective. It is suggested that small claim cases be grouped by counties, and placed in the small claims courts in lots or groups. This will necessitate fewer trips to the small claims court in the event that answers are received and it becomes necessary for the collector to be present to convey the hospital's story to the court.

The foregoing is a very general outline of the methods available to a collection department. In the event that the hospital fails to collect after all of these methods have been employed, there are three alternatives: (1) collection agencies, (2) attorneys, (3) charge it off.

COLLECTION AGENCIES

If policy permits, it is strongly recommended that full use of collection agencies' services be made. Ethical collection agencies have their place in the credit structure of business.

ATTORNEYS

Again, if policy permits, the use of attorneys and of legal suit is definitely recommended where the facts justify the contemplated action. As an example of where attorneys are necessary, estate cases in Massachusetts, if not paid within a year after the appointment of an executor, become legally uncollectible, and are only a moral obligation of the estate. It is suggested that the hospital's legal counsel give advice on estate cases in other states.

HOW MUCH COLLECTION EFFORT?

The size of the account usually governs the effort made to collect it. The following is a general summary of steps that may be taken to collect accounts of varying sizes:

$1 to $3:

1. A statement.
2. A printed reminder.
3. One strong appeal letter.
4. Charge off.

Send a list of these unpaid accounts to the credit bureau each month.

$3 to $15:

Steps 1, 2 and 3.

4. Letter threatening collection by third party.
5. Charge off and give to collection agency.

Time of entire procedure: not more than 45 days from date of discharge.

$15 to $50:

Steps 1, 2 and 3.

4. Telephone call.
5. Strong letter.
6. Threatening letter or threat to collect through small claims court.
7. Charge off and place for collection, or take patien. into small claims court.

Elapsed time: not more than 60 days from date of discharge.

$50 and over:

Steps 1, 2 and 3.

From that point individual treatment will pay off in better collections and better public relations.

Elapsed time and various steps would be subject to revision if patient answers or makes on-account payment. In that event each account should be handled personally.

Use the staff, the social service department, and the public relations department in all possible ways to effect and promote prompt payment of hospital bills.

IMPACT ON PUBLIC RELATIONS

All hospitals are dependent for operating funds on endowments, contributions, third party payments, and patient income. The board of trustees is responsible to the public for the proper use of all funds under its control, whether received from endowment or from the paying patient. The hospital is open to all who are sick and its first objective is the care of the sick, but it must maintain a healthy financial condition to remain at the service of the community. It must have as a prime objective the collection of all accounts, but must always remember the intangible elements of good will.

A sound credit policy, intelligently administered in a businesslike yet humane fashion, will result in the hospital's having a high standing in the community with good public relations. Surely people who expect to leave money to a hospital, or who contribute to a hospital through the Community Fund or otherwise, do not intend their contribution to be reflected as a charge-off of bad debts, debts which under a more realistic policy could have and should have been collected without damage to the well-being of the patient who owed a just bill and was economically and financially able to pay that bill.

We need an informed public, and it has only been within the past few years that hospitals have tried to tell their story to the public. The interpretation of the hospital's policies, particularly along credit lines, is of prime importance. If the public understands what a hospital is, how it operates, and the reason for its costs, the impact of the credit policy on public relations should be all to the good.

SPECIAL COLLECTION PROBLEMS

Special situations, while they do not affect the final bad debt loss of a hospital, are the responsibility in most cases of the credit manager.

Town, City, State and Federal Welfare Cases: These are the responsibility of various governmental agencies that pay for hospitalization. It is noted that in almost every instance the cost per patient exceeds materially the rate at which these agencies reimburse hospitals.

In the city of Boston, the average cost per patient day is $22, while the state of Massachusetts reimburses hospitals at $12 per day. The difference is a charge-off to free service, or what is sometimes called a "welfare allowance." The task of collecting from these governmental agencies is at times more time-consuming than collecting from personal responsibility cases.

Workmen's Compensation Cases: These are the responsibility of the in-

(*Continued on Page* 136)

Recipe for a Well Planned Kitchen

Mix the architect's skill in design with the administrator's knowledge of the hospital, and season with the dietitian's practical experience

ELIZABETH PERRY
Chief, Dietary Department
City Hospital, Cleveland

FOR many years the need for a new dietary department at City Hospital of Cleveland was recognized, and for as many years the dietitians were thinking in terms of a new department.

Today the shiny new structure is completed—planned by the dietitians, architect and superintendent who worked as a team, pooling their combined skills so that the demands of service from the dietary department would be met efficiently.

The old dietary department grew, "like Topsy," valiantly meeting the increased demands made on it through the years. The result was a workable department, but it had limitations because of lack of space and equipment.

Because this need was recognized, and long before funds were available for the building, plans were being made and research was started by the dietary staff, investigating improved methods of food service and planning the future goals of the dietary department when the plans would become a reality.

The salad finishing table, like the rest of the equipment, was designed to expedite the work and make life simpler for the workers. Architects who designed the new department are Small, Smith and Reeb of Cleveland.

The dietitian's rôle is equally as important in the planning program as that of the architect and the superintendent. To be a successful operation, the cooperation of all three is needed. Each has a certain contribution to make by virtue of his training and experience in specialized fields of work.

The architect has the knowledge of a certain given space as it relates to total plans and the placing and spacing of equipment. His is the theoretical point of view or approach. He has a knowledge of the plans of yesterday and today, as well as the trends of tomorrow, and contributes excellent suggestions for improved methods of operation.

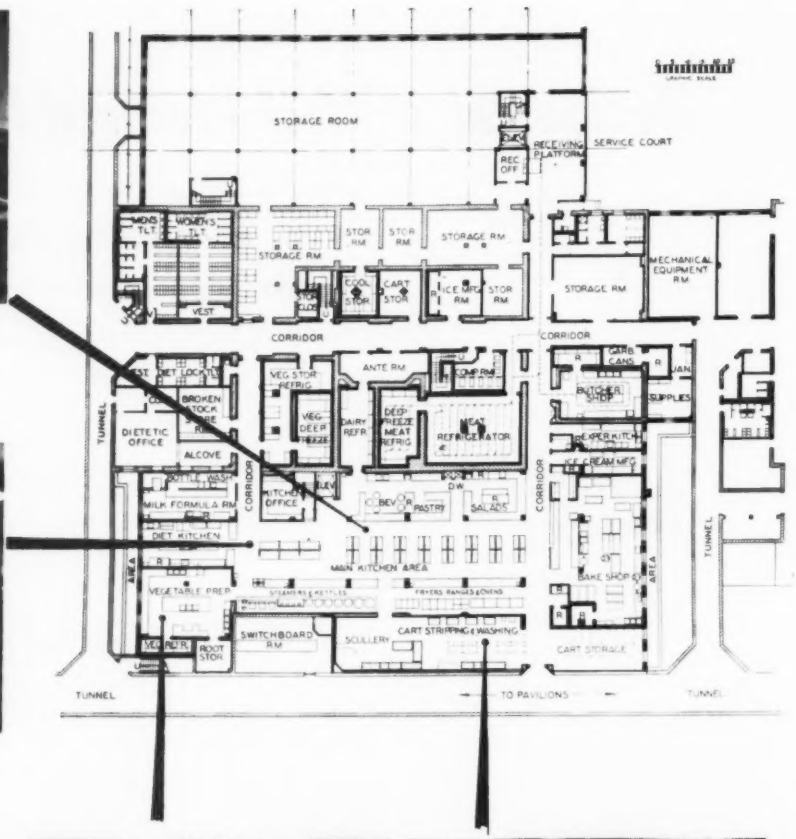
The dietitian, however, is acquainted with the working program and has the knowledge of production requirements, the present employe work loads, and the practical experience of equipment placement which contributes to efficient operation.

The superintendent knows the space requirements as well as the future plans of expansion for the hospital. He knows the financial limitations to be considered.

Therefore, the final picture can only be developed by the pooling of the

Above: Low table for loading milk on food carts; coffee urns showing storage space and masonry platform for easy maintenance.

View of the main kitchen showing cart stations, the steam kettles, the fry kettles, grills and roasting areas, bake shop area.



Above: Plan of the ground floor; arrows show position of various sections as shown in pictures in relation to the whole floor. Left: Vegetable preparation, including garbage disposal, finishing table, ice box for storage of finished products which are placed on racks that can be pushed in the ice box after being loaded. Right: Pot washing room, cart stripping area.

knowledge of these three people into a plan constructed in blueprints for the contractor to develop.

True, all kitchen layouts are based on years of experience by those skilled in kitchen planning, yet these basic principles must be modified to meet certain operating standards.

As the original plans are being studied, the employes who are doing the actual work—the cooks, bakers and butchers—yes, even the chief dishwasher mechanic—should be consulted for their suggestions. Each can give helpful hints on ease of operation in his unit, as can the dietitians who are supervising these areas. Placing confidence in these people, showing respect for their suggestions, will result in a better operating department.

The architect, the superintendent and the dietitian are the coordinators of these suggestions, and are the ones who make the final decisions, yet if the architect thinks he knows all, the superintendent thinks he knows all, or the dietitian thinks she knows all, and thus succeeds in overruling the considered judgment of the team, the finished product is not likely to be good.

The planning of the new kitchen at City Hospital was a great pleasure for all because of the cooperative attitude of all persons working on the plans; the architects were seeking information from our superintendent and the dietitians; the dietitians were learning from both of these people, studying all suggestions and the problems involved in the building. For example, a transformer caused a change in original plans and flow of work. The transformer could not be moved so the plans were revised around this installation.

Before the first blueprints were made, service demands of the dietary department for the future were studied: patient and personnel food service, teaching program, formula preparation, clinic instruction.

Progress in any field of endeavor does not *happen*. Progress is the result of study and hard work, stimulated by the established goals that have been set as a guide in all plans for the future. Questions must be answered and decisions made.

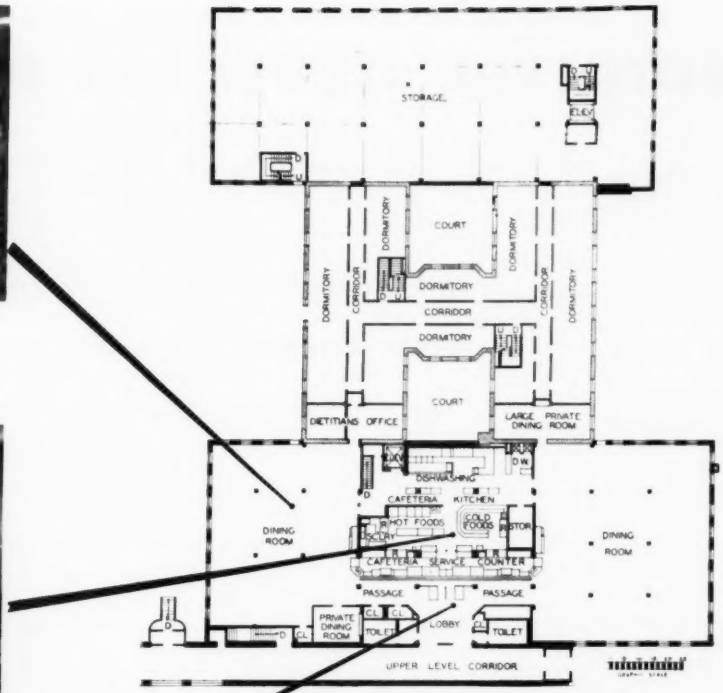
The questions we asked ourselves were:

1. What services would be included in the new two-story structure to be built?

Above: The west dining room showing the cafeteria counter looking from west to east. Decorations are cheerful and friendly.

Above: Salad and dessert preparation unit, which also shows a section of cafeteria cooking area, ice boxes and heated container.

Entrance to the cafeteria showing the west dining room and west side of double cafeteria counter.



The second floor of the two-story dietary service building is devoted to personnel food service. This unit is connected with the kitchen on the first floor by an intercommunications system. Arrows show the disposition of the areas described in the pictures in relation to the over-all floor plan.

2. What were the plans relative to actual food production?

3. Should the present menu pattern be maintained? (This decision was important because the type of menu dictates to some degree the equipment needs.)

4. What do we wish to accomplish with this new installation?

The decisions we made and used as the basis for the future plans were:

1. To correlate all dietary services in the new building, with the exception of patient food service, which is decentralized and satisfactory.

2. Plan work areas which will give a broader scope of work, with improved methods to ensure high standards of *served food.*

After these basic principles had been decided, one of the first jobs given to the dietitians was to list the amounts of raw food items for which storage facilities were needed (refrigerated and nonrefrigerated, deep-freeze or holding) and the amount of food used daily in food preparation. Since the consensus was that our patient-day would not increase, these amounts were to be based on past actual units of purchase. Large deep-freeze units were not a part of the old City Hospital equipment; therefore, the second consideration was given to future plans relative to increased use of frozen items which reflected directly on plans for deep-freeze installations. Items included were vegetables, fresh and frozen; fruit, fresh and frozen; meats, poultry, butter, eggs, broken stock, and so on.

Starting with the receiving platform, the flow of work was studied and the units were planned for production. The work load for each unit was submitted by the dietitian to the architect to be used as a basis for his plans.

The architects are people skilled in putting on paper ideas to scale. However, the dietitian also should have knowledge of scale drawings of equipment and work areas; it is helpful in arriving at the best placement of equipment for ease and economy of operation. Only then does one clearly understand the architect's problems, and realize how equipment when drawn to scale can fill up space. The architect and dietitian did spend many hours in adjusting work areas to space allotments.

Many blueprints were made before the permanent location for each work area was decided. There were 20 areas to be studied and planned, each unit a contributing factor in producing the planned menu, excepting the formula room. Our task was to set up each unit as we wanted it, relative to equipment

(*Continued on Page* 114)

PROTOTYPE STUDY: 200 BED HOSPITAL

All the facts about the 200 bed hospital as it exists today—comprising a useful tool for self-evaluation and an adaptive guide to administrative planning

LOUIS BLOCK, Dr.P.H.
Program Coordinator
Division of Medical and Hospital Resources, Public Health Service

THIS is the third in a series of prototype developments. The first two articles of the series, "The 50 Bed Hospital," and "The 100 Bed Hospital," appeared in the June 1953 and the October 1953 issues of The MODERN HOSPITAL. The reasons for the development of this series were explained in some detail in the first article.

It was emphasized that there was a need for making the tremendous store of hospital information available for general use; that certain of the data were arrived at through applying the proportionate variations from local averages in the areas where studies had been made to national averages; that a "prototype" is generally defined as a pattern that describes "what is" rather than "what should be"; that emphasis on the typical or average is beset with many dangers if not properly applied, and that it can be a useful tool for self-evaluation and as a general guide to administrative action when it is adapted to one's particular needs.

The following prototype is the third example of applying these technics and facts to a 200 bed nonprofit, general hospital.

BED DISTRIBUTION

Major. In more than half of these hospitals, medical, surgical, obstetrical and pediatric patients have beds specifically set aside for their use. For this reason they are considered as major services to such a hospital type and size group. Medical and surgical services combined account for approximately 69 per cent of all beds, obstetrics for 17½ per cent, and pediatrics for 13½ per cent. This means that the average 200 bed general hospital has 138 medical and surgical beds, 35 obstetrical beds, and 27 pediatric beds. The foregoing bed distribution will be affected by assignments to additional services discussed hereafter.

The distribution of beds by type of accommodation shows 13 per cent in private rooms, 45 per cent in semiprivate rooms and 42 per cent in wards. The average 200 bed general hospital therefore has 26 private, 90 semiprivate, and 84 ward beds.

Additional. In addition to the four basic groupings of patients in more than half of these hospitals, the 200 bed general hospital may make specific bed assignments for other patient groups. Because they occur in less than half of these hospitals they are considered as additional services. Table 1 indicates these additional services, frequency of occurrence, and average number of beds assigned them.

Bassinet Distribution. The average number of bassinets for newborn is the same as for obstetrical beds, 35.

More than 9 out of every 10 of these hospitals have infant incubators. They average 5 to 6 such units per hospital.

More than 1 in 2 have special nurseries for premature infants.

Closed Beds. One in 8 hospitals reported beds closed for all reasons. They averaged 24 beds per hosptial.

One hospital in 16 had beds closed for lack of personnel. They averaged 23 beds per hospital.

One hospital in 16 had beds closed for reasons other than personnel. They averaged 27 beds per hospital.

UTILIZATION

The kind, type and number of patients admitted to the 200 bed general hospital are as follows:

Admissions. An average of 6800 to 6900 patients is admitted during the year, averaging 34 to 35 admissions per bed per year.

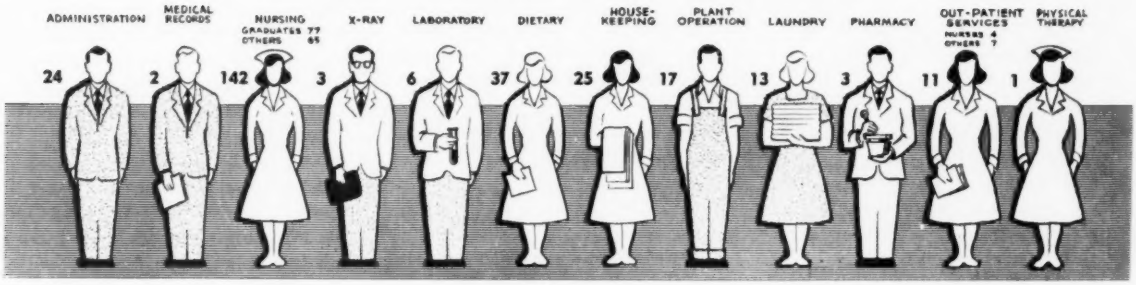
Of these admissions, approximately 31 per cent, or 2100 to 2125, are medical cases, 35 per cent, or 2375 to 2400, are surgical cases, 19 per cent, or 1325 to 1350, are obstetrical cases, and 15 per cent, or 1000 to 1025, are pediatric cases.

Births. There are approximately 1350 live births during the year. Of this number, 80 to 85 will be pre-

Table 1—Frequency of Additional Services

Patient Group	Frequency of Occurrence	Average Number of Beds Assigned
Isolation or contagious	1 in 5 hospitals	9
Nervous and mental	1 in 10 hospitals	21
Chronic	1 in 20 hospitals	25-26
Tuberculosis	1 in 25 hospitals	24

AVERAGE NUMBER OF PAID PERSONNEL



mature. There will be an average of 14 sets of twins during the year, and 1 set of triplets each year. There will be about 16 stillbirths during the year.

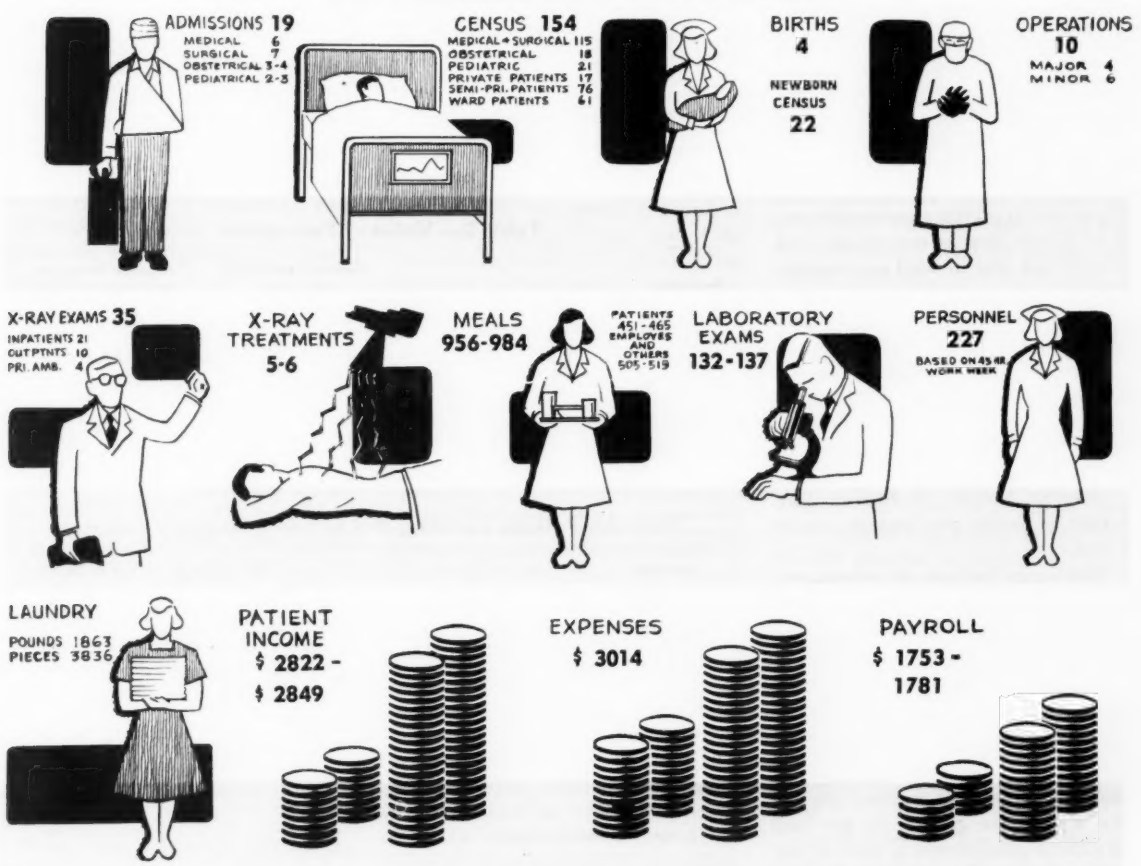
Deaths. There are approximately 220 deaths during the year, 155 of which are institutional (deaths occurring 48 hours or more after admission) and 65 are noninstitutional (deaths occurring within 48 hours after admission).

The gross death rate (total deaths divided by discharges) is around 3.2 per cent. This means that about 3 out of every 100 patients discharged die in the hospital.

The net death rate (institutional deaths divided by total discharges) is around 2.3 per cent. This means that 2 of the 3 deaths per 100 patients discharged are considered as institutional deaths.

There will be approximately 12 premature fatalities during the year.

AN AVERAGE DAY'S ACTIVITIES



In this prototype of hospital operation for the 200 bed nonprofit, general hospital, national data were used whenever available. Regional, state or special group information was adjusted to the national basis. This represents the composite or average of existing statistical data. As new or more refined information becomes available, the content may need revision. It does not generally reflect affiliated services with other hospitals and sources; nor does it necessarily indicate the ideal institution.

Autopsies. An average of 100 autopsies is performed during the year. This shows an autopsy rate of 45.5 per cent (autopsies divided by total deaths).

Patient Days of Care. The hospital provides around 56,000 days of care during the year.

Of this number, approximately 6500 are for obstetrical patients, 7500 for pediatric patients and 42,000 for medical and surgical patients.

Of the 56,000 days of care, about 6000 are in private accommodations, 28,000 in semiprivate accommodations, and 22,000 are in wards.

Newborn Infant Days of Care. In addition, approximately 8000 days of care are provided for newborn infants during the year.

Average Daily Census. An average of 154 patients is cared for in the hospital daily.

Of this number, 18 are obstetrical, 21 pediatric, and 115 medical and surgical.

Of the 154 patients cared for daily, approximately 17 are private patients, 76 are semiprivate, and 61 are ward patients.

An average of 22 newborn infants is cared for daily.

Percentage of Occupancy. The average annual percentage of occupancy approximates 76, varying from 60 to 70 per cent in private accommodations, 75 to 85 per cent in semiprivate, and 65 to 75 per cent in ward accommodations.

The percentage of occupancy approximates 50 to 55 for obstetrical services, 75 to 80 for pediatric, and 80 to 85 for medical and surgical services.

Newborn occupancy approximates 63 per cent.

Average Length of Patient Stay. Length of patient stay averages almost 8 days.

This varies by type of accommodation as follows:

Private	8 days
Semiprivate	7 days
Ward	10 days

Semiprivate patients usually stay a shorter time than do either private or ward patients. Among the usual explanations for such an occurrence is that the pressure of finances requires the semiprivate patient to get back to gainful employment as soon as possible. Private patients may be in a better position to afford a slightly longer convalescence in the hospital. Ward patients, on the other hand, may have other factors dictating or affecting the length of time they stay. Among these factors are usually those of more advanced cases of illness and home conditions not conducive to convalescence.

Length of stay for all patients varies by diagnosis as follows:

Medical	12-13 days
Surgical	8-9 days
Obstetrics	4-5 days
Pediatrics	7-8 days
Gynecology	6-7 days
Genito-urinary	10-11 days
Orthopedic	12 days
Ear, nose and throat	1-2 days
Ophthalmology	8 days
Other	6 days

More than two-thirds of all patients admitted are discharged within one week. The per cent of patients discharged according to length of stay shows:

Length of Stay	Per Cent	Cumulative
1 day	8	8
2 days	12	20
3 days	10	30
4 days	11	41
5 days	12	53
6 days	10	63
7 days	6	69
8 days	5	74
9 days	3	77
10-13 days	10	87
14-20 days	7	94
21-30 days	3	97
31 days and over	3	100

PERSONNEL

Numbers. The average number of paid personnel was 280 to 285 excluding interns, residents and students.

This amounts to an average of 180 full-time employes per 100 patients; 1.4 employes per bed, or 1.8 to 1.9 per occupied bed.

Job Vacancies. Three out of every 4 hospitals reported job vacancies. Of those reporting vacancies, 2 in 3 hospitals had vacancies in graduate nurse positions. They averaged 13 such vacancies per hospital.

Of those hospitals having vacancies, 1 in 2 reported them in positions other than graduate nurses. They averaged 9 such vacancies per hospital.

Governing Board. The average size of the governing board is 17 members.

Volunteers. Almost 1 in 2 hospitals has volunteers other than women's auxiliaries. They average 44 such workers per hospital.

Women's Auxiliaries. Two in 5 hospitals have a women's auxiliary. Their average membership is 375, and they have 51 members working in the hospital.

Administrator. The chief administrative officer is a physician in 1 hospital in 11, a graduate nurse in 1 hospital in 3. In more than half of the 200 bed general hospitals he is

Table 2—Value of Perquisites

Perquisite	General Staff Nurse and Clerks	Practical Nurse and Untrained Personnel
Single room	$25.00	$18.50
Double room	18.50	12.50
One meal	14.00	12.00
Two meals	29.00	24.00
Three meals	43.50	36.00
Laundry	4.50	4.00

Table 3—Policies Covering X-Ray and Laboratory Charges

Inpatients	Lab. Charges	X-Ray Charges
Same to all	23 per cent	15 per cent
Only ward different	40 per cent	47 per cent
Different to all	32 per cent	40 per cent
Flat rate to all	4 per cent	.....
Clinic Patient		
Same as ward	38 per cent	42 per cent
Different from ward	52 per cent	51 per cent
Same as private	10 per cent	7 per cent
Private Ambulatory Patient		
Same as private patient	95 per cent	95 per cent
Same as semiprivate	3 per cent	5 per cent
Different for all	2 per cent	.....

Table 4—Usual Charges for Special Services

Service	Private Patient	Semiprivate Patient	Ward Patient	Out-patient	Private Ambulatory Patient
Basal metabolism	$10	$10	$ 5	$ 5	$10
Electrocardiograph	$15	$15	$10	$ 5	$15
Cystoscopy	$15	$15	$ 5	$10	$15
Bronchoscopy	$10	$10	$10	$10	$10
Gastroscopy	$15	$10	$10	$10	$15
Tonsils and adenoids (Child-flat rate)	$25	$25	$25	$20	$25

Table 5—Usual Charges for Operating Room and Anesthesia

Service	Private Patient	Semiprivate Patient	Ward Patient
Operating room:			
Major	$30	$25	$15
Minor	$15	$15	$10
Anesthesia:			
Major	$20	$20	$15
Minor	$10	$10	$10

neither a physician nor a graduate nurse, but has some other background.

In 1 hospital in 5 the administrator is a graduate of a college course in hospital administration.

In more than half of the hospitals, the chief administrative officer is a male.

Other Categories. Nine hospitals in 10 employed a qualified dietitian.

One hospital in 2 employed a graduate physical therapist; 1 hospital in 21 employed a nongraduate physical therapist.

Three hospitals in 4 employed a graduate medical record librarian; 7 in 10 hospitals employed a nongraduate medical record librarian. This would indicate that about one-half of the hospitals employ both graduate and nongraduate medical record librarians.

One hospital in 3 employed a graduate medical social service worker; only 1 in 9 employed nongraduates.

One hospital in 9 employed a graduate occupational therapist; only 1 in 25 employed a nongraduate.

Length of Employment. One hospital in 6 reported its nursing director as being employed for less than 1 year in this hospital, and 1 in 7 reported the administrator as being employed there for less than 1 year.

SERVICES

Major. The following services are found in more than half of the existing 200 bed general hospitals.

X-ray diagnosis	99 hospitals in	100
X-ray therapy	7 hospitals in	10
Women's auxiliary	7 hospitals in	10
Patient's library service	3 hospitals in	5
Medical records department	98 hospitals in	100
Metabolism apparatus	96 hospitals in	100
Pharmacy department	9 hospitals in	10
Physical therapy department	7 hospitals in	10
Outpatient department	7 hospitals in	10
Clinical laboratory	96 hospitals in	100
Electrocardiograph	94 hospitals in	100
Medical library	9 hospitals in	10
Central supply	4 hospitals in	5
Blood bank	4 hospitals in	5

Additional. Services that might be provided but are generally found to occur in fewer than 50 per cent of the facilities are considered additional. The following indicates some of these services and the frequency with which they are provided within this hospital size and type group. Certain of these additional services may be provided through arrangements with other hospitals and sources.

Routine chest x-ray on admission	1 hospital in 4
Postoperative recovery room	1 hospital in 6
Children's educational program	1 hospital in 8
Social service department	1 hospital in 3
Occupational therapy department	1 hospital in 7
Cancer clinic	2 hospitals in 5
Dental department	1 hospital in 3
Electroencephalograph	1 hospital in 5
Mental hygiene clinic	1 hospital in 7
Training course, auxiliary nursing personnel	1 hospital in 4
School of nursing	almost 1 hospital in 2

DEPARTMENTS

Medical Staff. The average 200 bed general hospital has 145 staff appointments. Of this number, 61 are active, 16 associate, 50 courtesy, 10 consultant, 3 honorary, and 6 other types of appointments.

More than 9 in 10 of these hospitals have a chief of staff.

Almost all, 47 in 50, have chiefs of services.

Forty-nine in 50 have a written set of regulations.

Forty-nine in 50 have regularly scheduled meetings of the staff.

Forty-nine in 50 have standing committees of the staff.

Only 1 hospital in 5 allows nonstaff members to practice in the hospital.

More than 9 in 10 hospitals have restrictions on staff physicians' surgical privileges.

Three hospitals in 8 provide examining rooms primarily for ambulatory patients of the medical staff.

More than 1 in 7 hospitals reports physicians' offices in the hospital or on the hospital grounds for seeing private ambulatory patients.

Operating and Delivery Rooms. The 200 bed general hospital averages 5 operating rooms; 3 major and 2 minor.

The average number of operations approximates 3675 per year. Of this number, about 1525 are major and 2150 are minor.

The hospital averages 2 delivery rooms and 2 labor rooms. There are about 1350 deliveries per year.

Recovery Room. One hospital in 6 has a postoperative recovery room. They average 7 recovery beds.

X-Ray. Approximately 13,000 x-ray examinations are given during the year; 7750 for inpatients, 3500 for outpatients, and 1750 for private ambulatory patients.

In addition, approximately 2000 x-ray therapy treatments are given during the year.

Ninety-seven per cent of the hospitals have physician staff members specializing in radiology; 58 per cent have them full time, and 39 per cent, part time.

More than 9 in 10 hospitals have x-ray facilities available to private ambulatory patients of physicians.

Laboratory. Approximately 48,000 to 50,000 clinical laboratory examinations are performed annually; 42,000 for inpatients, 6000 for outpatients and 2000 for private ambulatory patients.

The ratio of these examinations to patient days of care is 0.7 of an examination per patient day for inpatients.

Ninety-three per cent of the hospitals have physician staff members specializing in pathology. Three hospitals in 5 (58 per cent) have them full time, and 1 in 3 (35 per cent) has them part time.

Forty-nine in 50 hospitals have all tissue removed in surgery routinely examined by a pathologist.

More than 9 in 10 hospitals have laboratory facilities available to private ambulatory patients of physicians.

Blood Bank. Four hospitals in 5 have a blood bank. Those having blood banks issue 1171 units of 500 c.c. each per year. This amounts to an average of 5.9 units per bed per year.

Their average stock amounts to 31 to 32 units.

Their bleeding capacity is 3.

Their source of blood supply is as follows: 73½ per cent from donors, 7 per cent from other hospitals, 6½ per cent from nonhospital sources, and 13 per cent from Red Cross centers.

Emergency Room. An average of 5000 patients will be treated in the emergency room during the year.

Nine to 10 per cent of them will be admitted to the hospital as inpatients.

Outpatient Department. Approximately 24,000 visits will be made to the outpatient department during the year.

About 3500 x-ray examinations and 6000 laboratory examinations are performed for these patients during the year.

Nursing. Almost one-half (43 per cent) of the nursing staff is nonprofessional.

If there is a school of nursing, the proportion of nonprofessional is about 42 per cent; without a school of nursing it is 46 per cent.

Dietary. An average of 350,000 to 360,000 meals is served annually; 165,000 to 170,000 are served to patients, and 185,000 to 190,000 to employes and other persons.

Nine in 10 hospitals employ a qualified dietitian. They average 4 such persons per hospital.

Nine hospitals in 10 use gas for cooking.

Almost 3 hospitals in 4 have mechanical centralized dishwashing service; 1 in 5 has mechanical decentralized service; 1 in 9 has manual decentralized service, and only 1 in 50 has manual centralized dishwashing service.

Two hospitals in 3 have centralized food service.

More than half of the hospitals (3 in 5) have selective menus. One in 3 has them for all patients and 1 in 4 has them for private patients only. Two hospitals in 5 do not have selective menus.

Laundry. Nine hospitals in 10 operate their own laundry. Those that do average 15 to 16 hospital beds per employe and require 13 to 14 employes per hospital. In these hospitals the laundry processes approximately 680,000 pounds, or 1,400,000 pieces per year.

Hospitals operating laundries have an average water consumption of 11,035 cubic feet per bed per year; those not operating laundries average 9277 cubic feet per bed per year.

Ambulance. Four hospitals in 5 report the provision of ambulance service; 1 in 8 own and operate their own ambulance service; 1 in 7 use city or publicly owned ambulances, and 3 in 5 use private nonhospital ambulances.

FINANCIAL

Assets. Total assets per bed amount to about $10,000.

Plant assets per bed amount to $6500, or about two-thirds of total assets.

Replacement Funds. Almost 1 in 2 hospitals indicate a need for replacement funds for obsolete equipment and service departments of hospital plants including replacement or expansion of service facilities and replacement but not expansion of bed complement.

This need amounts to between $675,000 and $680,000 per hospital.

Expense. Expenses approximate $1,100,000 per year.

Average expense per patient day amounted to $19.75, varying from $23 to $24 for private patients, $19 to $20 for semiprivate patients, and $18 to $19 for ward patients.

Average expense per patient stay amounted to $156.

Pay Roll. Average annual pay roll amounted to $640,000 to $650,000.

Average annual salary per employe approximated $2300.

Average pay roll amounted to $11.50 per patient day.

Average starting salary per month amounted to $218 for general duty nurses, $127 for untrained women, $143 for untrained men, $152 for clerks, and $154 for practical nurses.

Pay roll amounted to approximately 58 per cent of total expense.

Average annual salary of the administrator was around $10,500.

Perquisites. The value of perquisites per month varied as shown in Table 2 for general duty nurses, clerks, practical nurses, and untrained personnel.

Departmental Expense. The departmental breakdown of expense shows:

Administration and business office	11 per cent
Dietary	16 per cent
Housekeeping	5 per cent
Laundry	2-3 per cent
Plant operation	7 per cent
Medical and surgical	6 per cent
Operating and delivery room	6-7 per cent
Pharmacy	4-5 per cent
Nursing	25-26 per cent
Anesthesia	2-3 per cent
Laboratory	5-6 per cent
X-ray	4-5 per cent
Other	3-4 per cent

Income. Patient income for the year approximated from $1,030,000 to $1,040,000. Patient income per patient day averaged $18.50, varying from $27 to $28 for private patients, $21 to $22 for semiprivate, and $12 to $13 for ward patients.

Average patient income per patient stay amounted to $146.

Patient income amounted to approximately 94 per cent of expenses.

Room Charges. The average room charge amounted to $12.50 for single rooms, $10 for 2 person rooms, and $8.25 for multiperson rooms.

Laboratory and X-Ray Charges. The policies shown in Table 3 cover the making of x-ray and laboratory charges in hospitals.

The general practice for laboratory service is to charge private patients a higher rate than semiprivate patients; to charge semiprivate patients a higher rate than ward patients; to charge ward patients a higher rate than outpatients, and to charge private ambulatory patients a rate comparable to that for private patients.

The charges shown in Table 4 are the most usual charges for certain special services.

Operating Room and Anesthesia Charges. The most usual charges for operating room and anesthesia services is shown in Table 5.

Drugs. One in 2 hospitals charges for drugs carried on the nursing unit.

OTHER INFORMATION

Injuries. Employes averaged 10.45 injuries per 1 million hours of exposure, *i.e.* work. This amounts to 47 injuries per year for the 200 bed general hospital.

The average loss per injury is $400, or a total loss of $18,800 per year.

Of the 47 injuries, 9 to 10 are caused by sprains, 8 to 9 by falls, 7 by improper handling of material and equipment, 5 by unsafe practices, and 17 by other causes.

The average time lost per injury is 11 days, or 517 days per year for this size hospital. Nursing personnel accounts for 217 of these days.

Doctors, patients and the hospital benefit from

Physicians' Service Department

JOSEPH G. NORBY
Administrator Emeritus, Columbia Hospital, Milwaukee

ROBERT M. JONES
Assistant Administrator, Columbia Hospital, Milwaukee

THE hospital's rôle and obligation as a community health center have been recognized more and more in the last 10 years. At Columbia Hospital, Milwaukee, some years ago, a committee of the medical staff, the board of directors, and the administration set out to develop a program to meet this obligation.

Some of the things that had to be considered were that Columbia Hospital is situated near the northern boundary of the city of Milwaukee and close to several of the northern suburbs. It serves an area of perhaps 150,000 persons and is located in the line of traffic from this northern population center to the downtown area of the city. Many of the attending staff men have their offices in the business district and, consequently, their patients have to travel some distance in heavy traffic to visit the doctors' offices.

The hospital has, since its founding, placed heavy emphasis on its diagnostic facilities and endeavors to provide the attending physician with all of the personnel and equipment necessary to aid him in the most accurate and advanced methods of differential diagnosis. The committee concluded that these services should be made readily available to the ambulatory patient as well as to the inpatient and recommended that a department should be provided to give the patient who resides in the neighborhood served by Columbia an opportunity to meet his family physician near by, thus eliminating the long trip to the physician's office. In addition, the physician would have available to him at one place all the necessary facilities for diagnosis and treatment of outpatients, services of consultants, and so forth.

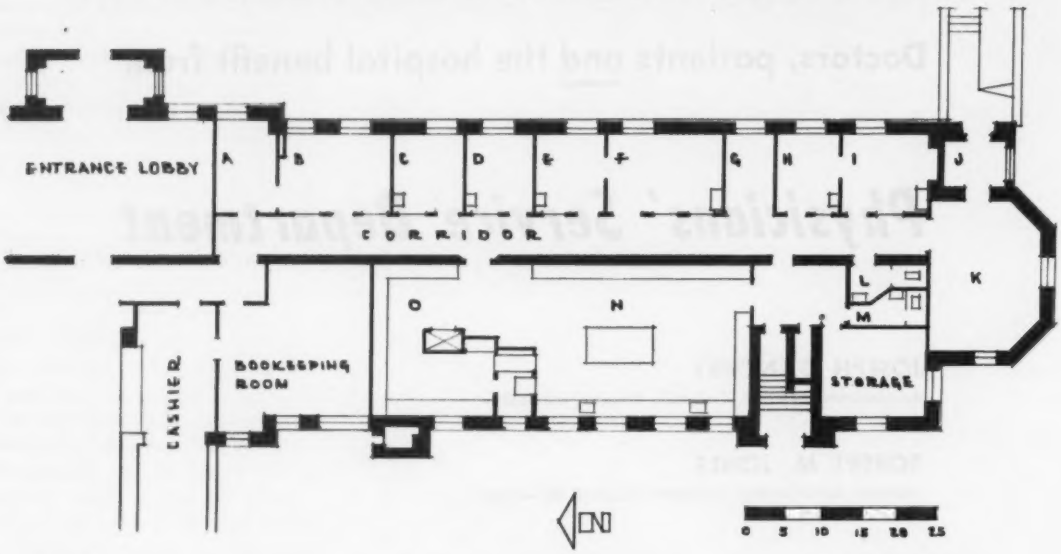
A new kitchen and dining room wing had just been completed, and the area occupied by the old kitchen and dining room was made available for the use of the physicians' service department. The space allocated consists of an outside entrance, a waiting room, a nurses' station, a toilet and six examination and treatment rooms. The unit was named the "physicians' service department."

In the waiting room are a desk for the receptionist-typist and suitable furniture for patients. In a sense it is a duplication of the waiting room of the doctor's office. Since the department occupies one side of a long corridor, the nurses' station was placed near the center between the second and third examining rooms. This station contains a desk for the nurse, a small table for the doctors to sit at while scheduling visits, and a file cabinet for the records of the department. Four of the examining rooms are 9 feet 6 inches by 9 feet, one is 9 feet 6 inches by 11 feet, and one, since it serves as an accident room as well as a treatment room, is 9 feet 6 inches by 15 feet.

Room No. 1 is furnished especially for proctoscopic and urological examinations and contains a sink and a wall type of cabinet. Room No. 2 has a connecting door with the first room as well as a door to the corridor. The equipment consists of an examining table, which was built in our carpenter shop, a small table for the use of the physician, two chairs, a built-in wall cabinet, a sink, and a combination desk and examining lamp. Ample storage space is provided by means of shelves under the examining tables. The tables are padded with ¾ inch sponge rubber mattresses. Each table is covered with a sheet, and over this is placed a disposable paper sheet, which is sanitary and is less expensive than utilizing a clean linen sheet for each patient. Each room is equipped with a call button which flashes a number on an indicator at the nurses' station. Three other rooms are similarly equipped.

Room No. 3 has a dual purpose, as the accident emergency room of the hospital and also as a treatment room for minor surgery and extensive dressing changing. In this room are a metal emergency table, which is equipped with a removable arm board, a portable surgical lamp, emergency oxygen and carbon dioxide tanks, instrument tables, several kick basins, a scrub sink with a knee valve, a built-in wall cabinet, a folding wheel chair, and several stools and chairs. The supplies include all necessary items for emergency work. However, this is not too important to us for not many off-the-street accident emergency cases are

PLAN OF OUTPATIENT DEPARTMENT, COLUMBIA HOSPITAL, MILWAUKEE



A—Office
B—Office
C—Consultation room
D—Consultation room
E—Consultation room
F—Emergency operating room
G—Nurses' station
H—Treatment room
I—Proctology
J—Vestibule
K—Waiting room
L—Toilet room
M—Toilet room
N—Central service
O—Sterile dressings

ESCHWEILER and ESCHWEILER, ARCHITECTS, MILWAUKEE.

brought in. Most of the police cases are taken to the County Emergency Hospital, and because Columbia is located in a residential area there are not many industrial accident cases in the neighborhood.

Each of the other rooms is furnished with a routine physical examination tray. Additional dressing or diagnosis trays are readily available at the central supply department, which is located directly across the corridor. The close proximity of the central supply department is advantageous, for it means that the physicians' service department can carry a minimum amount of supplies. Also, in cases of emergency, the nursing staff of the physicians' service department can be readily augmented from the personnel on duty in central supply.

The staff of the department consists of a graduate nurse who acts as the head of the department, a second graduate, a licensed practical nurse, and a receptionist. The department is open from 8 a.m. until 9 p.m. Monday through Saturday, and from 8 a.m. to 5 p.m. on Sundays and holidays. Emergency cases coming in after the department is closed are checked by the central supply nurse until 11 p.m. and the night supervisor after 11 p.m.

In general, patients, with the exception of emergency cases, are seen in this department only by appointment. The nurse in charge maintains an appointment book and schedules the patients both as to time and room, upon notification by the doctor concerned. At the time of scheduling the purpose of the examination is indicated so that the nurse may have any necessary equipment ready and may prepare the patient prior to the arrival of the physician. Since there are only six rooms available, the scheduling phase is most important.

When the patient arrives, the receptionist checks the schedule to make sure that the patient has an appointment and then makes out the only hospital record which is kept on such patients. This record is a three-part combination form made up with one-time carbons. The original is the charge copy, the duplicate is the cashier's copy, which is given to the patient after the examination has been completed, and the triplicate is the department file copy.

Space on the 3½ by 7¼ inch form is allotted for the name and address of the patient, the name and address of the person responsible for the bill, a few lines on which the treatment given or supplies used are described, a pricing space, and a price code. Since it is easier for the accounting department to price the charge form from a standard price listing, necessary deviations, dependent on the amount of supplies used, are indicated by the nurse by checks in the code boxes. Thus, the charge for a minor dressing change may be $2, but the nurse may notice that the physician, in making the dressing change, used more material than is normally used. In this case, she would put a check mark in the proper space to indicate that the charge should be increased to $2.50 for that particular patient.

After the identification information has been obtained and entered on the charge form, the patient is escorted to the proper room for the examination or treatment desired. At the conclusion of the treatment, the nurse writes on the form indicating what was done and separates the three copies. The yellow copy is given to the patient along with instructions to take the form to the cashier's office for payment. At the end of each day the white copies are forwarded to the accounting office so that patients who did not pay at the time of the treatment may be billed for the services.

The pink copies are filed in the department by date. Most of the patients complete the transaction at the time of the visit, but there are some who are frequent visitors or who for other reasons do not pay at the time of their treatment and are billed on a monthly basis.

If the physician desires to send the patient to any other department of the hospital, he ceases to be a patient of the "physicians' service department" and must be considered a regularly registered outpatient. Ordinarily, all outpatients are requested to stop at the admitting office of the hospital to be admitted. However, to save the patient the necessity of going through another department, the typist-receptionist, when so requested, fills out an outpatient admission form for the patient and makes proper distribution of the copies of the form. All emergency cases, even though treated in the physicians' service department, are admitted as outpatients so that a hospital number can be assigned to the record of the emergency treatment, which is a hospital record.

Filing space is maintained for medical records of the patients of the physicians' service department. However, such records are kept only at the discretion of the physician. Each physician furnishes his own record forms and writes his own records. These are private records and are not processed in any way by hospital personnel. Several of the physicians, especially when seeing a number of their patients in this department, have their own office personnel accompany them to make records of treatments and examinations

The hospital has endeavored to provide the physician with facilities similar to those he has in his own office. However, the hospital carries its service farther, for it places at the disposal of the physician all the staff and equipment of its adjunct facilities. This is a service not only to the physician and the patient but also to the hospital. About 40 per cent of the patients seen in the physicians' service department become registered as outpatients and utilize the services of the adjunct departments. This can be a big factor in the activity of those departments. When this department opened, 100 patients were served during the first month; now more than 1400 are processed each month, and the number is increasing.

The rapid increase in the number of patients seen in this department is an indication of the reaction of the staff physicians and patients. Patients like the service because they are relieved of the necessity of seeing the physician in his downtown office and they may obtain all necessary services, medication and so forth at one source.

Operating this department is another way in which a hospital may fulfill its obligation to the community by creating a medical center to serve the health needs of all the citizens. It also is a source of added income and creates an interest in the hospital on the part of those members of the community who might never use its services as bed patients.

The hospital makes further use of the department by centering the employe health service activities there. All employes are given a complete physical examination at the time of employment, plus periodic checkups. Examinations are scheduled and given in this department, and employes report here for first-aid care and assistance in medical problems.

Care is taken, however, that the facilities of the department are not utilized by personnel for therapeutic measures. Employes who seek medical care for injury or illness not classified as occupational are referred to a staff physician for private care. Each employe has a medical record showing the original physical examination and any subsequent examinations given or treatments rendered. These records are kept in a locked file cabinet, the keys of which are entrusted only to the nurse in charge and the staff physician responsible for the employes' health service.

SPACE IS PROBLEM

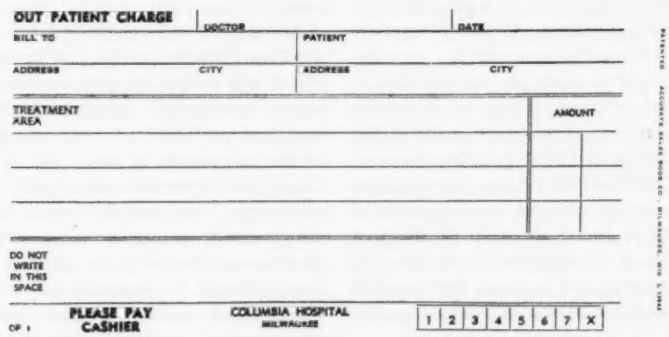
The major problem relative to this department the hospital faces today is a lack of additional space. The number of patients cared for has more than doubled in the years since its start and the number of employes required to operate it has been increased from one full-time and one part-time to four full-time persons.

Another problem at times has been staffing on week ends, holidays and evenings, as the doctors frequently use the department extensively when their own offices are closed. This has been solved by the addition of a licensed practical nurse who is on duty during odd hours.

The patient likes the service afforded by the department because it provides him with convenient consultation, x-ray, laboratory and pharmaceutical service at one place. It eliminates parking problems and traveling about in congested business areas and is much simpler for the physically handicapped patient. It also reduces the cost of medical care to the patients because some work at least can be done on an outpatient basis that might otherwise require hospitalization.

We feel that the development of the physicians' service department has contributed to developing good will for Columbia Hospital and created a worth-while service in full harmony with the demands the public is presently making on hospitals.

The only hospital record kept on outpatients is this three-part combination form. On it are recorded the name and address of the patient and the person responsible for payment, description of treatment and supplies used, a code for pricing and space for the amount of the bill.


OUT PATIENT CHARGE
DOCTOR
DATE
BILL TO
PATIENT
ADDRESS
CITY
ADDRESS
CITY
TREATMENT AREA
AMOUNT
DO NOT WRITE IN THIS SPACE
OP 1
PLEASE PAY CASHIER
COLUMBIA HOSPITAL MILWAUKEE
1 2 3 4 5 6 7 X

Depreciation in Hospital Accounting

1 ACCOUNTING MUST TELL THE TRUTH

PAUL D. SHANNON
Controller
Royal Victoria Hospital
Montreal, Que.

THE question of depreciation in hospital accounting seems to have become the most controversial and least understood single topic in the entire hospital financial field, and although I hesitate to enter such discussions at arm's length, Professor Morey's article on Page 73 of the September 1953 issue of The MODERN HOSPITAL only adds to the existing confusion, and I, as no doubt will many of my colleagues, feel that some clarification is essential on such an important issue.

What Professor Morey fails to point out is that depreciation, like any other accounting procedure, is merely "a means to the end" and not the end in itself. Like so many other authors who have dealt with this subject he bases his analysis on procedures rather than principles, and when this is done the fundamental facts are often overlooked.

Accounting entries must tell the truth and, unless they do so, they are wrong. Most accountants disagree with one another on matters of procedure or specific methods of application, and I must admit that I do not agree with certain methods outlined by Messrs. Roswell and Martin but closer investigation indicates that these gentlemen are closer to truth than they are given credit for being by Professor Morey.

In order to clear the air a little, we must remember that "depreciation" is a word developed to express a fact, just the same as "power," "light," "heat" and "oxygen" have been chosen to express facts. We should not confuse the concept of depreciation accounting by endeavoring to point out that whereas it may be fine in profit making concerns it does not apply in nonprofit organizations. Profits, deficits or source of funds have no bearing on the existence of depreciation: If it exists, it is a fact; if it is a fact, it must be recorded. To follow this line of thought we must first determine whether or not depreciation is a fact. If we determine that we require buildings and equipment to give service to the patient, just as we require food, medical care, and nursing care, we must then acknowledge that depreciation is a part of that service and must be accounted for if we are to obtain the true cost of service; to exclude any component of such service would be incorrect.

Now that we have established principle, let us review procedure. Throughout Professor Morey's article, there is an underlying basic truth, that is, the evidence of incorrect bookkeeping in the hospital field insofar as depreciation is concerned. However, this is not due to the fact that hospitals are nonprofit organizations as opposed to profit making ventures, or even due

(*Continued on Page* 87)

2 YES, BUT WHAT IS THE TRUTH?

LLOYD MOREY
President, University of Illinois
Royal Victoria Hospital
Montreal, Que.

I AGREE wholeheartedly with Mr. Shannon's statement that "accounting entries must tell the truth and, unless they do so, they are wrong." Truthful reporting should be a goal of every accounting system. Determination of what the truth is, however, is not a simple matter in many areas. Any discussion which tends to further the search for truth in these areas is desirable. My article in the September issue of The MODERN HOSPITAL was intended to point out some serious discrepancies in theory found in much of the past discussion of depreciation in hospital accounting, and to point out some of the wide variations in practice in that area.

Accounting theorists and practitioners have long recognized that the principles of accounting for profit-seeking enterprises and the principles of accounting for enterprises operating without the profit motive are not the same.

Accounting for profit-seeking enterprises should yield information which will enable the periodic calculation of net profit to approach truth as nearly as possible. A necessary part of the calculation of net profit is the charge for depreciation of tangible capital assets. The tangible capital assets are gradually used up in the production of revenue; therefore, the costs of the assets should be matched, in a systematic and rational manner, against the revenues produced over the life of the assets.

Consideration of depreciation is

appropriate, therefore, in the case of accounting for proprietary, profit-seeking hospitals. The article in the September issue of The MODERN HOSPITAL was, however, as stated in its introductory paragraph, intended to apply to public and endowed hospitals —nonprofit-seeking institutions—and not to proprietary hospitals.

Accounting for nonprofit-seeking institutions, as pointed out in the September article, does not involve a periodic calculation of net profit.

In many instances the tangible capital assets are donated to the hospital corporation or provided for it by a governmental body through tax revenues or the proceeds of bonds issued upon the general credit of the governmental body. "Depreciation" in the physical sense of the word occurs, as Mr. Shannon stresses at length, yet "depreciation" in the accounting sense is not a proper subject of an accounting entry because the assets cost the hospital nothing. Even in the instances of assets purchased at fair market values by the nonprofit-seeking hospital, the accounting consideration of depreciation is not appropriate because the tangible capital assets are not held for the production of income, but as a means of providing a service. Depreciation, unless it involves a funding of cash, has not, therefore, been considered by authoritative accounting groups cited in the September article to be a proper item to enter in the accounting records of nonprofit institutions. Thus, it would seem that Mr. Shannon has committed the error of confusing the physical concept of depreciation with the generally recognized accounting concept of depreciation.

Mr. Shannon does recognize, in the concluding portion of his letter, the desirability of putting aside cash for replacement of hospital assets, and the necessity for strict adherence to fund accounting principles in the bookkeeping for such cash transfers. These were two of the major points in the September article. The journal entries suggested in that article were presented in order to show that entries could be made in accord with good fund accounting practice. I agree with Mr. Shannon that all accountants need not use the same procedures as long as all procedures used are correct in principle. The entries advocated by the American Hospital Association committee are clearly not correct in principle.

3 THE EVIDENCE FAVORS DEPRECIATION

HERBERT E. KLARMAN
Assistant Director
Hospital Council of Greater New York*

FIFTY years ago depreciation of capital assets was a controversial question in accounting for business. It was finally settled by the exigencies imposed by the federal income tax.

Notwithstanding the dangers of indulging in historical analogy, the moral for depreciation accounting for hospitals seems to be obvious. Here, too, the controversy is likely to be resolved as a matter of policy, not by the requirements of technical accounting *per se*. Of greatest force among the factors that favor a depreciation charge on hospital assets appear to be the increasing importance of third party payments as a source of hospital income and the difficulties generally encountered in financing the replacement of obsolete plant.

It is realistic to stress in this connection the preponderant weight of policy framed under the influence of the broad trends that shape hospital finances. It is not at all realistic to concede that depreciation of hospital assets is unwarranted on technical accounting grounds. Quite the contrary appears to be true.

CASE AGAINST DEPRECIATION

The case against depreciation of hospital assets, particularly plant, consists essentially of three arguments:

1. The voluntary hospital is a nonprofit organization. It does not run the risk of distributing excessive dividends, with the resulting impairment of investment capital. Accordingly, there is no occasion for the hospital to charge depreciation on its assets.

2. Typically, the plant of the voluntary hospital has been paid for by the community through philanthropic contributions. There are no costs for the hospital to recover.

3. Moreover, where depreciation is charged by a hospital, the accumulated reserve is usually not funded. It follows that the community will still be required to pay for the replacement of plant, just as if depreciation had not been charged in the first place.

Each of the three points has a certain degree of validity; it is also largely beside the point. The distinguishing, nonprofit, characteristic of the voluntary hospital is significant for many purposes, but not for the question of whether hospitals should charge depreciation on capital assets. A depreciation charge is in order, regardless of the source of capital funds. Provision for funding of the depreciation reserve is a policy issue to be determined by the hospital's board of trustees; it is not an accounting problem.

NATURE OF CAPITAL ASSETS

Of course, the voluntary hospital is a nonprofit organization which does not distribute dividends. It is also a going concern in command of manifold resources, with which it produces the services that the community demands. Among those resources are plant assets with a service life longer than the customary accounting period of one year. If all assets had equal service lives that coincided with the duration of the accounting period, there would be no question of the propriety of the depreciation charge in hospitals any more than in business. Under such conditions all costs would be current costs and all expenditures would be actual expenses. Such, however, are not the facts, either in hospitals or in business. A capital asset continues to yield services long after it is acquired. It is important to record the flow of these services over the limited service life of the asset.

It is undeniably true that if the community provides funds for the construction of hospital plant, it is the community that incurs the costs, not the individual hospital. That is not, however, a valid reason for disregarding these costs, aside from any question whether the community will continue to provide capital funds for hospitals in the future. As is the case in business today, it is not unreasonable to expect that hospitals will increas-

* The views presented in this article are the writer's; they do not necessarily reflect those of the hospital council.

ingly rely on internal funds for financing construction.

COMPARISON OF COSTS

Why should capital costs be recorded, regardless of the source of funds? Largely because cognizance of total cost is an essential prerequisite for intelligent decisions with respect to the allocation of the community's resources among their alternate uses. Such resources are always scarce, in the sense that man's wants are endless and expanding.

Consider, for example, the problem whether to devote additional money to hospital care or to home care. The former may seem to be cheaper than it actually is, if the provision of capital for hospital construction is neglected. On the other hand, if capital costs are to be taken into account as a lump sum when incurred, hospital care would appear to be far costlier than it actually is. It is perhaps indicative of the consequences of these alternatives—*i.e.* omitting capital costs or charging them currently as a lump sum —that it is usually easier to finance new hospitals than it is to finance replacements because philanthropic contributions are more readily forthcoming for the former, and that difficulties are frequently encountered in modernizing hospitals and in adopting mechanical devices because they appear to be so costly on a current cash basis. A charge of depreciation on assets renders the costs of the different services and departments of hospitals more nearly comparable, as well as the costs of the same service or department over a period of time.

ECONOMIC ACCOUNTING

Another reason that lies in the realm of economic accounting is the desirability of recording the utilization of all resources. To neglect the use of capital assets of hospitals is to fail to record the services of a substantial aggregation of capital. (The Administrators Guide issue of *Hospitals*, June 1953, estimates the value of all hospital plant assets in the United States at $7.5 billion.) It has been well stated that the services of a hospital plant are no less valuable for having been paid for by the community in advance. This point has received recognition from the U.S. Department of Commerce. In preparing the authoritative estimates of national income and product, it includes an allowance for depreciation of hospital assets in the total figure on consumer expenditures for hospital service.

Since it is necessary to record hospital costs, how should it be done? If capital costs were regular or small, they would be recorded on a current basis at the time of occurrence. There would be no depreciation problem. In fact, and almost by definition, capital costs are irregular and substantial. Are they to be recorded when incurred; as regular, periodic charges over the life of the asset, or not at all? There are no other possibilities. Clearly the second one, that of charging depreciation, is the most reasonable.

Where are the costs to be recorded? For continuing usefulness they should appear on the books of account of the hospital. That is where the capital assets are located and utilized. Even when the asset is paid for by the community, its recording on the books of some other social agency would seem to serve little purpose.

Generalization beyond the scope of the issue at hand is almost as dangerous as proof by historical analogy. The excuse for either is that it often proves challenging. The unique, distinguishing characteristic of the voluntary hospital in our society is its provision of services in the absence of the profit motive that prevails in business. The hospital aims to provide the most and best services possible within the limits of its total income, which is derived from diverse sources. To provide services to patients the hospital must hire employes and procure food and supplies. These have to be paid for. In accounting for expenditures, what differences are there between a hospital and a business?

PHILANTHROPIC INCOME FOR OPERATING PURPOSES

Indeed, it is possible to prove much too much by stressing the fact that the community is the source of capital funds of hospitals and that, consequently, these funds need not be considered in hospital accounting. The community chest is also a source of annual income for hospitals, and of a similar nature but, perhaps less directly so, is the hospital's income from endowment. Both defray part of the operating expenses of the hospital. Inasmuch as all operating expenses are recorded on the hospital's books as they occur, is a segment of such expenses equal to the amount defrayed by philanthropic contributions to be deducted from total expenses at the end of the year? That would seem to be the logical extension of the argument that hospitals must not charge depreciation on plant assets because they were purchased by philanthropic gifts. That such a subtraction is not carried out in practice is sensible recognition of the fact that in disposing of the available hospital income every dollar, whether obtained from philanthropy or from patients, is of equal value.

FUNDING OF RESERVE

The proposition that a depreciation reserve for hospital plant should be funded—that is, an equivalent sum be invested in liquid assets—has widespread support. Among many who advocate charging depreciation in hospitals there is agreement that funding of the depreciation reserve is desirable as a matter of policy, although it is not an essential prerequisite for the depreciation charge itself. Among those who object to the depreciation charge, the frequent absence of funding is a major argument. The point usually made is that when the time comes to replace the plant the community will be tapped just the same. Finally, even those who object to the depreciation charge for hospitals on technical grounds seem to approve of a fund for capital replacement.

In business, of course, a depreciation charge on assets is allowed without reference to any provision for funding. There appears to be no reason why a hospital cannot be allowed to do something just because it also happens to be a business practice. Nor is there any apparent reason why a hospital's board of trustees, which is charged with the legal and moral responsibilities for rendering adequate hospital care and which usually includes a substantial representation from business, cannot be entrusted with discretion in this matter as it is in other, weightier matters.

UNSOLVED PROBLEMS

It is recognized that a policy of charging depreciation on hospital plant poses many problems that remain to be solved. For one, even funding a depreciation reserve does not ensure that adequate funds will be raised to finance capital replacement, if the price trend is inflationary. Whether depreciation should be based on original cost or on replacement cost is still a moot point in accounting for business; it constitutes no special problem in the hospital field. Suffice

it to say that the consensus among accountants today favors original cost as a basis for the depreciation charge. There is considerable difference of opinion among economists.

Third parties purchase care from government hospitals as well as from voluntary hospitals. The question may be asked whether government hospitals should also charge depreciation as an element of full cost, which is generally regarded as a basis of charges to third parties. The answer appears to be in the affirmative, in light of current thinking regarding proper accounting practices on the part of governmental enterprises, particularly those that are not essentially sovereign in nature. That the books of governmental hospitals have not been set up for this purpose is no proof that they need not or cannot be so set up in the future.

If a hospital plant is ancient and the records of costs and past depreciation are scanty, a depreciation charge computed on costs may be an unrealistic objective. During the transitional phase, as the practice becomes widespread, it may be preferable in many instances to set the depreciation allowance at a percentage of operating expenditures. In purchasing hospital care under the government reimbursement formula, the federal government adopted this device in the interests of efficiency of reimbursement and uniformity of treatment of vendors.

There are undoubtedly a number of difficult problems in the realm of technical accounting, which are complicated in hospitals by the necessity for maintaining several separate funds. These problems call for continuing study by experts in an effort to achieve reasonable, uniform and effective solutions that are consistent with the changing demands of the times. It may be expected that the professions of accounting and hospital administration will join in such a cooperative venture and press the effort to evolve effective procedures for charging depreciation on hospital assets.

Accounting Must Tell the Truth

(Continued From Page 84)

to a lack of knowledge by persons actively engaged in the field. It is almost entirely due to overenthusiasm in developing methods and perhaps some lack in strength of convictions and a forgetfulness that every accounting entry must record a fact. The subject of depreciation has been abused, both in writing and in application, more than any other single item of expense, but to disagree with the "fact" of depreciation because errors have been made in its application and recording is a line of thought which is difficult to justify.

Depreciation is a method adopted to record the utilization of a deferred charge to operations as a justifiable component of the cost of providing that service. The recovery of the cost of this component of depreciation is another matter entirely and should not cloud the issue. What we are primarily concerned with here is the accurate determination of the unit cost of service rendered regardless of who pays the bill or who donates funds or provides grants for buildings and equipment. Since a discussion of depreciation methods must of necessity involve fund transfers where different funds exist, a word on "Fund Accounting" might be appropriate. It should always be borne in mind that hospitals are encouraged to adopt fund accounting because this system more accurately portrays the facts. The following extract from the Canadian Hospital Accounting Manual is quite clear on this point.

"The various aspects of hospital financial and economic activity have very definite lines of authority, divisions of responsibility, and variations of proprietorship within a single institution. Unlike commercial or industrial organizations, hospital assets, liabilities and capital vary in accordance with source, application and responsibility, and limitations are imposed automatically on the distribution and utilization of the hospital dollar. It is therefore apparent that the accurate recording and portrayal of hospital financing must coincide with the financial divisions of the hospital's economic structure"—thus, fund accounting.

Since depreciation is the utilization of assets owned by one fund, through the provision of service in another fund, a fund transfer is automatic and these facts must be recorded with the account receivable (due from other funds) being set up in the books of the giver, and the account payable (due to other funds) being set up in the books of the receiver. Again, the discharge of this obligation is another matter and does not affect the recording of the facts at this point.

As to funding depreciation (cash transfers), those who are in a position to do so and have stayed as closely as possible to the "facts" and have applied these funds judiciously will find themselves in a healthy position in years to come. However, those who utilize depreciation funds for purposes not in accordance with intent do so at the risk of an excessive maintenance program in years to come, with a possible adverse affect on the standard of care provided. Those who ignore depreciation entirely cannot be said to be conducting the administration of their hospital along orderly and factual lines.

You will have received or read a multitude of arguments, both pro and con, on depreciation, but I venture to say that an analysis of these arguments as related to facts (*i.e.* "what has happened") will cause the majority of such arguments to disappear into thin air.

To disagree with methods is every accountant's prerogative—to disagree with facts is not accounting at all.

I hope that, if Professor Morey has the opportunity of reading this article, he will accept it in the spirit in which it is written, with the understanding that an incorrect interpretation by the layman of an article written by a person in such an authoritative position as the one he holds may tend to undo much of the good work that the A.H.A. and individual accountants have accomplished in the field of hospital accounting.

Centralize Patient Transportation Service

to cut down employes' "running time"

and step up the efficiency of the nursing service

MARK BERKE
Director, Mount Zion Hospital, San Francisco

ALTHOUGH centralization of function does not necessarily result in increased efficiency or reduced costs, its selective use may be highly effective in certain operations, and patient transportation is one area that readily lends itself to this type of planning.

It is a common experience to observe aides and orderlies idling in the x-ray department, for instance, while waiting to return a patient to his room or ward; and a discussion with the nursing director will often show that 20 per cent or more of the time of floor personnel is spent in transporting patients to and from the various diagnostic facilities and other places in the hospital. Inasmuch as graduate nurses as well as auxiliary personnel are involved, a hidden dilution of nursing care is immediately apparent and, because supervision is difficult on errands of this nature, an unfair temptation for unauthorized visiting and idleness is placed before the personnel concerned.

Faced with this problem and with the need to conserve scarce pay-roll dollars, Mount Zion Hospital of San Francisco decided that, as far as its own situation was concerned, the most expedient solution was to organize a new department, *i. e.* transportation service. The new service, utilizing specially trained transportation aides, is under the supervision of a dispatcher who, because of her familiarity with the layout of the hospital, is able to evaluate correctly the amount of time her personnel spends on each task.

From a central desk equipped with ample telephone service, and with adjacent seating space for temporarily unoccupied aides, the dispatcher receives calls from the head nurse, giving the name of the patient and his destination, and routes a transportation aide to the appropriate floor. In order to avoid errors in patient identification, the aide reports directly to the head nurse, and is accompanied by the latter to the patient's room. At this time, it becomes the head nurse's responsibility to decide on the type of conveyance to be used.

Having delivered the patient to his destination, the transportation aide telephones the dispatcher and is either sent on another errand or asked to return to the desk to await further calls. Thus, if the original destination was the x-ray department, no time is wasted by any employe while the film is being taken; instead when the patient is ready to be returned, the x-ray department itself calls the transportation desk and an aide promptly appears to accompany the patient back.

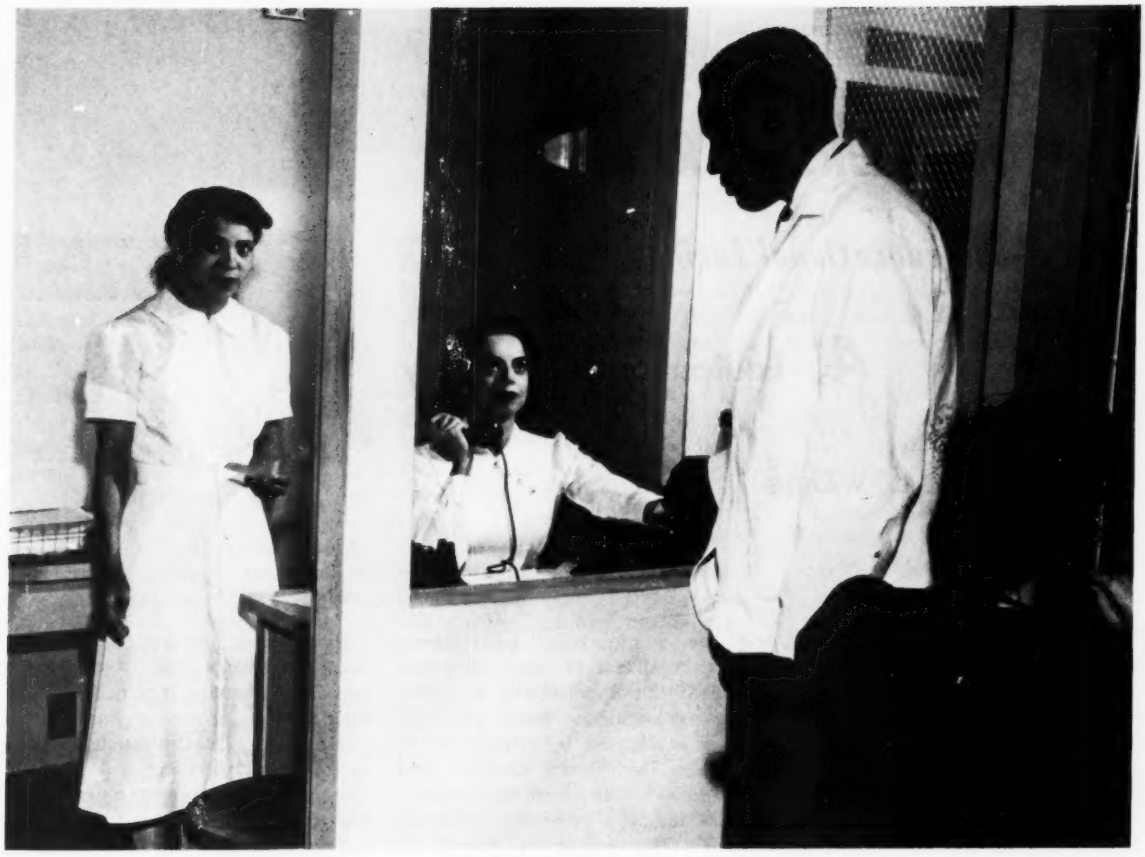
At its inception, the new department was staffed by the transfer of four nurse's aides and two orderlies from the nursing department. In retrospect, however, this may have been a mistake, because, naturally enough, the nursing department took the opportunity to rid itself of its most undesirable employes. It would seem better to begin with personnel recruited especially for the job and thus assure a more satisfactory service.

The only serious problem that arose was that of nurses who asked the transportation aide to perform additional errands when she arrived to transport a patient. Although the supplementary requests were reasonable, they interfered with the dispatcher's schedules and often resulted in delays and misunderstandings elsewhere. However, when the situation was explained to the nurses, they cooperated quickly and the abuse was eliminated.

The transportation service proved successful from the beginning. Originally contemplated as a 9 a.m. to 5 p.m., six-day program, within a few days it was extended at the request of the nursing department to a 7 a.m. to 7 p.m., seven-day operation. This of course, necessitated the transfer of additional personnel from the nursing department. The scope of the service was rapidly broadened, also by demand, and now includes not only the transportation of patients to and from diagnostic and therapeutic facilities but also all admissions, transfers, and discharges. In addition, various nonpatient activities are covered, such as the conveying of blood, drugs and personal belongings, and the morning collection of laboratory and x-ray requisitions, together with a thrice daily pick-up of urine and stool specimens.

A new major function has recently been added: room service for patients. A card at the bedside informs the patient that when he has some personal needs, such as cigarets or a magazine, a telephone call to the transportation service will get him speedy attention. If the patient has no telephone available, the call is placed by any of the floor personnel. Little additional work has been added to the transportation service because the dispatcher simply assigns the job to the next transportation aide going to that particular floor, but the comments from appreciative patients have been gratifying.

In order to obtain the maximum benefit from the department, an ori-



Above: The dispatcher at the transportation desk routes an aide to the appropriate floor when a nurse requests an escort for a patient. Adjoining the dispatcher's desk are seats for temporarily unoccupied aides. Below: This card informs patients that their "room service" wants will be promptly attended to—a service that is much appreciated.

entation program has been planned covering instruction to the aides on their relationship with the patient and with other personnel, as well as with some principles of body mechanics. The latter is especially important, inasmuch as lifting patients is a frequent occurrence.

The net result has been that all personnel assigned to a patient unit now remains on that unit, with no excuse for leaving it, except for emergencies; and the nursing department is delighted with its own increased efficiency. This, of course, was the original intent of the program, but we have also received an unexpected dividend. Apart from an ultimate number of seven employes transferred to the new department (serving an institution of 298 beds), the nursing department found that it was eventually able to effect an additional reduction in its auxiliary personnel of 10 aides. Thus, the transportation service has not only solved a chronic problem but has also effected a significant savings in payroll expense, and it would seem that this or a similar plan is worthy of consideration by most hospitals.

Basic Steps in Planning

THE NURSES' RESIDENCE

and Educational Facility

4. Equipment and Supply

LOUISE O. WAAGEN
Chief Nurse Consultant
Division of Hospital Facilities, Public Health Service, Washington, D.C.

GENERAL STATEMENT

SUGGESTIONS for planning physical facilities have been presented in the previous section of this guide. This section deals with its companion piece, the provision for equipment and supply.

"Hospital Equipment and Supply Lists"[1] (pp. R1-R7) contains an excellent presentation of a detailed, systematic method for compiling equipment lists for hospitals (with example work sheets). The method is equally applicable to education and residence units and many of the lists are transferable. It is recommended as a useful guide to planning equipment for educational and residence units.

Following are excerpts from that publication, which express fundamentals of planning for equipment:[2]

"Even before the *building* is a physical entity, while it is still in the planning stage, an organization must be established for selecting and purchasing the . . . equipment. A single individual should be made fully responsible for coordinating the job."

"The administrator, purchasing agent, consultant or other individual assigned the responsibility for planning the equipment must make sure that it is adequate in quantity and of a quality that assures durability and performance. *All* items should be of a size and type to fit . . . particular needs. The equipment should be properly apportioned and budgeted to the various services of the facility so that unduly expensive or elaborate equipment is not provided for some services . . ., necessitating the use of cheap and inadequate equipment for other services."

"Begin the equipment planning early. Selection, delivery and placement of equipment take time. It is evidence of good planning to have the equipment ready to move in as soon as the building is completed."

Selection of equipment and supplies requires the special competencies and meticulous attention of experts in that field. Although the responsibility for equipment is given to the administrator, purchasing agent or equipment consultant, he requires the advice and help of others in compiling lists and in selecting specific items. The advice of nutritionist, maintenance, housekeeping and other appropriate competencies is essential for details of equipping their respective units. The nurse consultant is responsible for providing a statement of general requirements and specific suggestions concerning equipment essential to individual activities of education and to meet residence needs of students.

In order to give such advice, the nurse consultant must have general knowledge of course content and know what method of classroom presentation will be used. Demonstrations, laboratory and lecture classes will each require specific equipment, differing for each course.

Careful analysis is required to determine the patient care materials needed. Local policy will determine to what extent patient care materials will be established in the educational area or requisitioned from the hospital or other sources. There should be a clear delineation of materials that will be permanently allocated to the educational unit and those that will be supplied temporarily from the hospital or other departments. Equipment and supplies which are used for teaching purposes must be in harmony with those in the clinical areas where the students care for patients.

Ample time must be given to compiling the lists. What constitutes "ample time" is a variable affected by the magnitude of the total building program, competencies available, and cooperative efforts. It may be a month, a year, or more.

In the compilation of equipment and supply lists, it is advisable to consider them by classifications based on methods of purchase and also accounting practices in regard to depreciation. Such group classification helps to establish a proper time sequence for consideration and purchase of each group of items.

(Continued on Page 140)

[1] Hospital Equipment and Supply Lists. Division of Hospital Facilities and Division of Medical and Hospital Resources, Public Health Service, Department of Health, Education, and Welfare. Reprinted from the Hospital Purchasing File, 29th (1952) edition.

[2] Ibid. Italicized words indicate changes for purposes of focus on education and residence units rather than on a hospital facility.

This is the fourth and concluding article in the series on planning education and residence units for nurses.

About People

Administrators


Dr. Wilmar M. Allen

Dr. T. Stewart art Hamilton, director of Newton-Wellesley Hospital, Newton Lower Falls, Mass., since 1946, has been appointed director of Hartford Hospital, Hartford, Conn., effective February 1. Dr. Hamilton succeeds **Dr. Wilmar M. Allen,** director for the last 17 years. Formerly, Dr. Hamilton was assistant director of Massachusetts General Hospital, Boston, and, for four years while in the army, was adjutant and then executive officer of the army's 6th General Hospital. He is a fellow of the American College of Hospital Administrators and New England regent of the college. In 1951 he was president of the Massachusetts Hospital Association; previously he had served as chairman of the association's council on administrative practice and as a trustee. Currently Dr. Hamilton is chairman of the Massachusetts association's council on government relations.

Dr. Allen, who is widely known for his activities in hospital and medical associations, joined the staff of Hartford Hospital as pathologist and bacteriologist in 1925. He was named director of the institution in 1936. He is a fellow of the American College of Hospital Administrators and served as its president in 1949-50. He has also been president of the New England Hospital Assembly, and has served on various councils and committees of the A.H.A. Following his retirement, Dr. Allen will continue to serve the hospital as a consultant.


Dr. J. A. Katzive

Dr. J. A. Katzive, director of the health services division, United Auto Workers, C.I.O., Detroit, has resigned to become executive director of Maimonides Hospital, Brooklyn, N.Y., effective January 1. A graduate of the Ohio State University School of Medicine, Dr. Katzive served as medical supervisor of the outpatient department at Montefiore Hospital, Pittsburgh, during 1933-34. From 1934 to 1941 he was assistant director of Mount Sinai Hospital, New York City; from 1941 to 1952 he was director of Mount Zion Hospital in San Francisco. He has served as president of the California State Hospital Association and the San Francisco Hospital Conference. He is also a fellow of the American College of Hospital Administrators and a member of the American Hospital Association and the American Medical Association.

Eva H. Erickson, administrator of Galesburg Cottage Hospital, Galesburg, Ill., since 1949, has been appointed administrator of Children's Orthopedic Hospital, Seattle, effective February 1. She will succeed **Lilian M. Thompson,** who is retiring as administrator of Children's Orthopedic after many years of service. Miss Erickson has been director of nursing and the school of nursing at Galesburg before going to Olean General Hospital, Olean, N.Y., in February 1947 as superintendent. She is a graduate of the Michael Reese Hospital School of Nursing, Chicago, and received a bachelor of science degree from Columbia Teachers College, and, in 1947, a master's degree in hospital administration from Northwestern University. A former president of the Illinois Hospital Association, Miss Erickson holds memberships in the American College of Hospital Administrators, the National League for Nursing Education, and the American Nurses' Association.


Harvey Schoenfeld

Harvey Schoenfeld, assistant director at Montefiore Hospital, New York City, since 1951, has been appointed director of Nathan and Miriam Barnert Memorial Hospital, Paterson, N.J., effective January 1. Mr. Schoenfeld, a graduate of Brooklyn College and the Wharton School of the University of Pennsylvania, was assistant director of Maimonides Hospital, Brooklyn, and director of management engineering and personnel administration of St. Vincent's Hospital in New York City before accepting the position at Montefiore Hospital. He holds membership in the American College of Hospital Administrators, the American Hospital Association and the American Public Health Association.


Kenneth Williamson

Kenneth Williamson, executive secretary of the Health Information Foundation since 1950, has been named director of the Washington, D.C., service bureau of the American Hospital Association. Formerly associate director of the A.H.A., Mr. Williamson was a member of the Chicago staff for six years before joining the foundation. Earlier, Mr. Williamson had been executive director of the Association of Western Hospitals and the Association of California Hospitals. He has also been assistant director of Blue Cross in Southern California and administrative assistant at Good Samaritan Hospital, Los Angeles. He succeeds Albert V. Whitehall.


A. J. Borowski

Anthony J. Borowski has been named administrator of Citizens Hospital, Barberton, Ohio. Previously chief of the hospital facilities division of the Ohio Department of Health, Mr. Borowski will take over his new duties on January 1, succeeding **Jane B. Sherrill,** who served as administrator for nine years before resigning. He attended the school of hospital administration of the University of Chicago and received his degree of master of business and hospital administration in 1951. Before accepting his former position, Mr. Borowski had been with the health department of Michigan.

(*Continued on Page* 176)

Volunteer Forum

Conducted by Raymond P. Sloan

Most administrators believe

Businessmen Make the Best Trustees

DANIEL S. SCHECHTER
Bloomfield, N.J.

A SURVEY of 50 hospital administrators regarding the wisdom or otherwise of including physicians on the hospital's board of trustees resulted in a majority vote against the practice, with a few dissenting opinions.* With that question disposed of, the next problem was, who, then, should be selected for membership on the board of the average voluntary hospital?

Although many administrators stated that representation should be "as broad as possible," more were concerned about finding persons truly interested in their hospitals' welfare. They are eager that, in the words of R. K. Swanson, superintendent of the Swedish Hospital in Minneapolis, board members should have "a real interest in the institution, the ability to contribute intelligently to the formation of its policies, and, what is very important, have time to devote to their duties and not be so occupied by other interests that attendance at meetings and working on committees becomes of secondary importance."

Eva H. Erickson of Galesburg Cottage Hospital, Galesburg, Ill., said, "Hospital boards need men and women who have vision and courage to fulfill that vision; who have a following and who have willingness to influence the following toward support of the hospital; who have discernment, understanding of what illness does to people, and who are willing to have this understanding implemented in such a way as to provide the greatest good for the greatest number; who know or are willing to learn the principles of management and employe relations. Most important of all, board members ought to be people who are willing and able to work together, to respond to effective leadership, and to broaden their horizons so that they can understand the complexity of the operation of modern hospitals."

THE BOARD NEEDS LEADERS

Clyde W. Fox, administrator of Washoe Medical Center, Reno, Nev., said he thought "there is an overimportance put on who should be represented on the board." In his view, "it is more important that the board be composed of the natural leaders of the community; busy people who get a lot done and who have their fingers on the pulse of the community." He indicated the danger in a dogmatic rule assuring representation to any specific group without considering the personality of its representative. For example, he said that although boards of nonsectarian community hospitals often think it well to include a representative of religion, "there is as much competition between churches as in other things. One minister may not represent all religions and you may find your hospital, instead of being nonsectarian, having an angle toward one particular religion."

Although some administrators suggested that an over-balance of businessmen on the board might promote "over-economy to the discomfiture of the patients," it appeared that most administrators looked to business representatives as the largest ingredient of a successful board. Some felt that businessmen had general managerial skills requisite for board members, skills which administrators do not have time to teach to untutored members. Also that business executives were more likely to appreciate the proficiencies of the hospital director.

A Kansas director urged: "Give me a board of successful businessmen who say what they think, are interested in the hospital, and will take the time to study and advise in the formulation of general policies. A man who understands the problems of management can be oriented in a relatively short period of time to the philosophies of nonprofit organization, public health and community responsibilities. On the other hand, it seems impossible to attain any degree of success in conducting orientation courses in finance, accounting, economics, personnel relations and other such matters." An attribute he said he found most frequently in businessmen was an ability to sit down together and to thrash out a problem until it was resolved. "Trustees who lack the background and training to participate in a given discussion are dissatisfied and lose interest. With this lack of interest, one or two trustees then dominate the policy formulation, and the basic purpose for the establishment of a board is defeated." In denying that hospital boards should be chosen to represent particular groups or a community cross section, this director pointed out that "there are many other ways in which an intelligent board and administrator can recognize the pressures, desires and needs of groups. Well organized and functioning auxiliaries, good medical staff, administration and liaison, coupled with inquisitive management, will provide a fairly accurate guide to the community pulse." (*Continued on Page* 94)

* This is the second of two articles on the question of the composition of the hospital board of trustees. The first article, "Do Doctors Belong on the Board?" was presented in the December issue of The MODERN HOSPITAL.

Dr. John C. Mackenzie, director of the Touro Infirmary in New Orleans, said, "The board of a voluntary hospital should be composed of a cross section of the business and professional men of the community, exclusive of the medical profession, except that there may be, by the invitation of the board, a representative on it from the medical staff whose function will be to interpret to the board such resolutions of the medical staff as may be passed by it from time to time."

When asked what occupations administrators found most desirable for hospital board members, those interviewed suggested bankers ("However, you may have a banker whose chief interest is to see that no money is ever spent."), lawyers, engineers, insurance brokers ("With the present growth of insurance of all types throughout the United States, and with hospital payments ranging from 40 to 85 per cent by third parties, a distinct contribution can be made by these representatives."), hotel, club or restaurant managers ("for problems relating to food and possibly housekeeping"), and teachers ("for their interest in intrahospital education").

Also, representatives of the utilities, newspapers or radio stations ("preferably the owner"), industry ("connected with large enterprise and interested in human relations"), general contracting, and labor ("It is better to have labor's opinion expressed on the board and debated out in the open than it is to have them 'boring from without.' I believe a high type of union official who sees beyond the personal angle of getting what he can, being acquainted with problems of the hospital to the extent that he sees that profit is not a motive but that service to the community is, will help to have a better understanding of the conflicts that hospitals have suffered from union relationships." And from another administrator: "In this period of high taxes, monied people are not in so good a position as they used to be to give large sums. Therefore, organized groups in the community, including labor, should be represented and be expected to help support the community's hospital.").

It was suggested too that hospitals have a "grass roots" representative, really a "patient" representative, whose contribution would be to serve as a sounding board for the public.

Although several administrators suggested the inclusion of wealthy, retired individuals, the majority point of view was expressed by one who observed that "having as board members only those whom we hope will leave large sums of money to the hospital is outmoded." If this new philosophy is being put into widespread practice—and my survey was of insufficient scope to ascertain this—then it represents quite a drastic change. "The history of the modern hospital," said Dr. E. M. Bluestone, "provides abundant proof that standards of selection have not been uniform and have not always been wisely observed in accordance with the individual needs of hospitals. Men of wealth who are members of the governing group may or may not be liberal in their contributions. Men of social position may or may not understand the true position of the hospital in the particular community it serves. The qualification of education and social-mindedness is the one most commonly overlooked and is often forgotten in the presence of social position."

Whether staff physicians should be members of hospital governing boards, and what the composition of such boards should be, are questions that have been debated for many years by administrators working with both groups. Among hospital directors interviewed in this survey there was decided uniformity of thought. The majority agreed that physicians on hospital boards would be placed in a position in which they could do justice neither to themselves nor to the institution. They considered that whatever benefits physician-trustees offered in most cases were far outweighed by the disadvantages. Some administrators suggested that a rare individual who, while a practicing physician, still had sufficient objectivity of judgment, and time, energy and a bent for board duties, would be an administrator's delight.

The thinking of most hospital heads seemed to be summed up in these words of C. E. Wonnacott, administrator of Latter-Day Saints Hospital in Salt Lake City: "I thoroughly believe that there has never been a time when it was more important to generate a real spirit of camaraderie between the board of trustees and the medical staff, but I seriously doubt the wisdom of having a medical member on the board itself. I believe that other methods of establishing an effective liaison are more prudent."

It Coughs When the Patient Can't

Technic of employing exsufflation with negative pressure: a mechanical method of eliminating retained bronchial secretions

GUSTAV J. BECK, M.D., and ALVAN L. BARACH, M.D., With WILLIAM H. SMITH

THE intention of this paper is to describe the technic of operation of recently developed apparatus designed to produce a high velocity of air movement from the lungs during expiration, namely, "Exsufflation With Negative Pressure," or E.W.N.P.[5]

Exsufflation with negative pressure has been reported the most effective of the physical methods recently employed to produce a high expiratory flow-rate from the lungs and thereby eliminate bronchopulmonary secretions.[1-5]

The need for removing mucoid or mucopurulent exudate from lungs is especially evident in patients with an ineffective cough due to poliomyelitis, myasthenia gravis and other neurological disorders with paralysis of the muscles of breathing and a variety of clinical illnesses characterized by severe impairment of the physiologic mechanism of coughing, which may result in pulmonary atelectasis and bronchopulmonary infection, as in patients with intractable bronchial asthma, pulmonary emphysema, bronchiectasis, lung abscess, and respiratory depression induced by anesthetic or sedative drugs.

The method consists, first, of gradual inflation of the lungs with positive pressures of 30 to 40 mm. Hg over a 2.5 second period of time. Second, after the lungs have been expanded in this manner, the pressure in the upper respiratory passageway is dropped to 30 to 40 mm. Hg below the atmosphere in 0.02 seconds by the swift opening of a solenoid valve connected to a negative pressure blower and maintained at that level for 1.5 seconds. This is followed by the next inspiratory cycle. A mask or mouthpiece may be used to connect the patient to the apparatus.

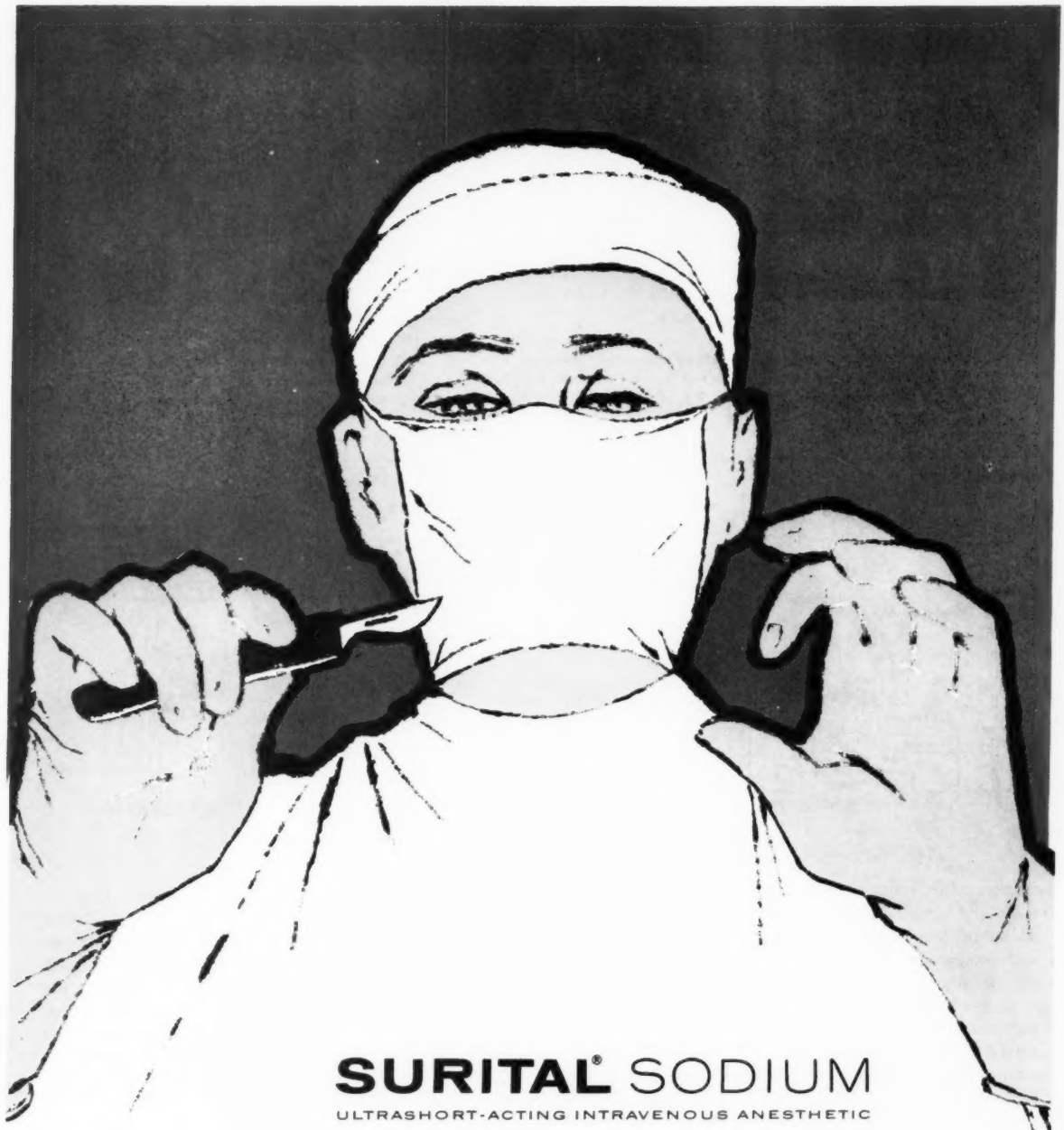
The purpose of the initial full expansion of the lungs is to facilitate the passage of air beyond a mucus plug into the alveoli distal to the obstruction, by widening the bronchial tree. In dogs, pressures of this magnitude result in an increase of the bronchial diameters to approximately twice that present during the expiratory cycle. No harmful effects have been found when a 40 mm. Hg inspiratory pressure is gradually developed over 2.5 seconds and followed by an abrupt pressure drop to minus 40 mm. Hg or more as in the exsufflation procedure. However, lower inspiratory pressures may be employed. The swift pressure drop from above to below the atmosphere at the start of expiration results, in many instances, in expiratory flow-rates equal to or greater than those produced during a natural cough of a normal subject. The maximal expiratory volume flow-rate attained depends on the device employed.

Four models of E.W.N.P. are available. In one of them the patient or physician turns an off and on switch to initiate opening and closing of a solenoid valve, which connects the mouth or face to the suction or positive pressure side of a blower. (Fig. 1.) Expiratory flow-rates produced by this device are lower than those obtained with the larger models but, in clinical practice, exsufflation with negative pressure has been adequately accomplished in many cases with flow-rates of 6000 to 7000 cc. per second. Expiratory volume flow-rates of 8000 to 10,000 cc. per second are produced in a pressure as well as a manually operated, spring controlled model; a fourth pressure controlled type contains an inspiratory and expiratory motor blower unit and achieves expiratory volume flow-rates as high as 20,000 cc. per second. The two latter pressure controlled devices provide a wide use of positive or negative pressures, continuous or intermittent, and may also be used for resuscitation. (See Figs. 2, 3, 5.)

In previous papers, exsufflation was the name given to the expulsion of air simply because of the elastic recoil of the lungs and chest wall when a 40 mm. Hg intrapulmonary pressure was quickly dissipated. The addition of negative pressure at the start of the expiratory cycle markedly enhanced the expiratory flow-rate and thereby the force acting upon retained secretions in the lungs, especially when the alveoli themselves had previously be-

From the Department of Medicine, College of Physicians and Surgeons, Columbia University, and the Presbyterian Hospital, New York City.

This study was supported by a grant from the National Foundation for Infantile Paralysis.



SURITAL® SODIUM

ULTRASHORT-ACTING INTRAVENOUS ANESTHETIC

SURITAL sodium (thiamylal sodium, Parke-Davis) produces smooth anesthesia with rapid, quiet induction and prompt, pleasant recovery.

Detailed information on **SURITAL** sodium will be mailed you on request.

MEDICAMENTA VERA

Parke, Davis & Company

DETROIT, MICHIGAN

Fig. 1

Fig. 5

Fig. 2

Above, left to right: Fig. 1: Hand-operated solenoid E.W.N.P. Fig. 5: Exsufflator With Negative Pressure. Fig. 2: Another model of hand-operated E.W.N.P. Below: Fig. 3: Diagram of the Exsufflator With Negative Pressure. Fig. 4: Diagram of solenoid valve during inspiration and expiration.

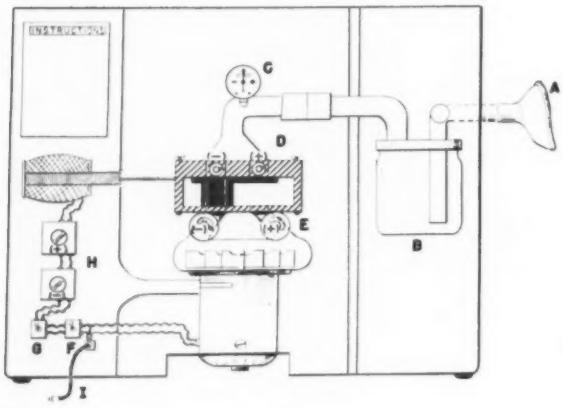


Fig. 3

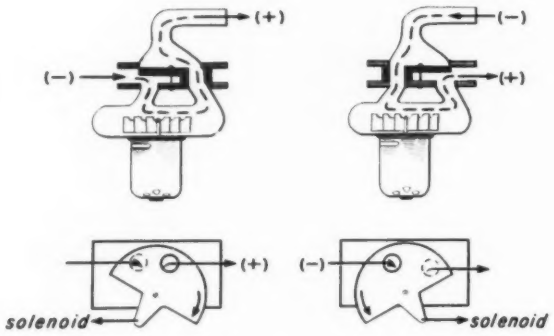


Fig. 4

come aerated by adequate lung expansion.

The apparatus illustrated in Figures 3 and 5 consists of a motor-blower unit with negative and positive pressure outlets leading to a solenoid valve in turn connected to a mask or mouthpiece (A) by plastic tubing. The duration of inspiration may be varied by a control (H) but is usually set for adults at 2.5 seconds. Similarly, the duration of expiration may be predetermined, generally at 1.5 seconds but this may be modified by a control (H).

When the plastic tubing near the mask connection is closed with a cork, the inspiratory and expiratory pressures may be set by manipulating positive and negative pressure controls (E). These are ordinarily set at 40 mm. Hg. In addition, the volume of air delivered during the inspiration is regulated by the volume control valve (D) so that a gradual filling of lungs to a pressure of 40 mm. Hg takes place in 2.5 seconds.

If smaller pressures are desired at the start of treatment to acquaint the patient with the mechanism, positive pressures of 10 or 15 mm. Hg may be employed with similar negative pressures. As the patient becomes accustomed to the sensation of rapid delivery of air during expiration, both the positive and negative pressures are gradually increased.

During the actual operation of the E.W.N.P. apparatus a mask or mouthpiece is attached so that no leakage takes place. It is not necessary to use a nose clip when the mouthpiece is used. The mask must be held tightly to the patient's face either by the operator or by the patient himself. The current which operates the motor blower (F) and the solenoid valve (G) is turned on by switches. At the end of 2.5 seconds, the lungs, having been inflated by the predetermined pressure, the reversal of the solenoid valve (Fig. 4) then brings about an expulsive blast of air from the lungs.

The patient should be instructed to inhale gradually and, when the valve is reversed, to exhale quietly. It is unnecessary to ask the patient to blow out quickly because the bronchial tree may be contracted prematurely thereby. The elastic recoil of the lungs, plus the suction effect of the vacuum-cleaner blower, are adequate to accomplish a high velocity of air movement without the patient himself attempting to force a rapid movement of air. After an exsufflation has been accomplished, another gradual increase in inspiratory positive pressure follows. In most instances, five exsufflations are used, followed by an interval of 1 minute before the succeeding course, in order to avoid hyperventilation. A total of six to 10 courses of five exsufflations is generally employed at one sitting. This treatment may be repeated at one-half, one, two or three hour intervals, as indicated in the individual case. In most patients, especially those with poliomyelitis, exsufflation is best carried out in the head-down position in order to obtain the additive effect of gravity.*(Continued on Page 100)*

*TRADEMARK
PFIZER SYNTEX PRODUCTS

NOW..

antibiotics and steroid hormones

for immediate intramuscular use...

Steraject®

sterile, single-dose disposable cartridges

In the hospital, Steraject cartridges—used with the fast-action Steraject syringe—have the dual advantage of *convenience and economy.*

On any service, Steraject can help you save:

storage space
replacement and breakage costs
time and work per injection
sterilization procedures

STERAJECT conserves staff work on floor and in the pharmacy because each cartridge contains an accurately premeasured dose.

STERAJECT . . . symbolizes easy-to-use intramuscular administration of hormones and antibiotics.

For details see your Pfizer Hospital Representative.

PFIZER LABORATORIES *Brooklyn 6, N. Y.*
Division, Chas. Pfizer & Co., Inc.

a wide variety of antibiotics and hormones for every hospital need.

In many patients with respiratory difficulties, including those with pulmonary emphysema, bronchial asthma, and bronchiectasis, a variable degree of bronchospasm may be present. For this reason, inhalation of a bronchodilator aerosol, such as 1 per cent epinephrine, or 2.25 per cent racemic epinephrine, is generally employed immediately prior to treatment. The bronchial lumen is additionally increased to some degree by the vasoconstricting effect of nebulized epinephrine with 1 per cent neosynephrine.

The use of inspiratory pressures of 40 mm. Hg, which produce a high degree of expansion of the chest wall, is at times followed by pains over the sides or front of the thorax. These pains may originate in the chest musculature as they disappear within three to five days of treatment. Stretching of the pleura may also be responsible for some of the pain. In no instance did distress occur severe enough to interfere with or modify exsufflation with negative pressure.

AVOID HYPERVENTILATION

The volume of the plastic tube between the face and the solenoid valve increases the dead space, but since tidal airs of 1500 to 2500 cc. take place during exsufflation, no increase in carbon dioxide tension would be produced; on the contrary, hyperventilation is the syndrome to avoid since the minute volume of ventilation during five or six exsufflations may be 7500 to 15,000 cc. An increased oxygen concentration in the inspired air may be produced by adding a small amount of oxygen, *i.e.* 4 liters per minute, in the tubing adjacent to the mask or through a nebulizer attached to the mask.

The plastic tubing from the mask to the solenoid valve is also a reservoir where mucoid or mucopurulent secretions are deposited. In addition, a bottle trap may be employed in this apparatus to collect excessive amounts of mucus or pus before the air column enters the valve. Water or 1:1000 benzalkonium chloride may be placed in the bottle to provide a moist surface for the exsufflated air. The glass bottle trap supplied in one such device reduces the expiratory flow-rate from 10,000 to 8000 to 9000 cc. per second. It is only used for patients with abundant secretions, the direct adapter connection being employed for routine operation.

Following a treatment in which a noticeable amount of expectoration is present in either the tubing or in the trap, soap and water are used to cleanse the apparatus. The mask or mouthpiece as well as the plastic tubing are cleaned with soapy water and subsequently placed in 1:1000 benzalkonium chloride for sterilization when the apparatus is transported from patient to patient.

Although no set rules can be outlined, patients with poliomyelitis as well as those with bronchiectasis and pulmonary emphysema, frequently employ a program in which four treatments a day are used, consisting of six to 10 courses of five exhalations each. Under these circumstances the respiratory tract may be adequately cleansed of previously retained secretions.

In addition to its use as a method of cleansing the respiratory tract, the apparatus may be employed for resuscitation by setting an inspiratory pressure to 16 mm. Hg with a negative pressure of 6 mm. Hg. The inspiratory and expiratory cycles can be regulated in time to be more nearly equal if desired; the flow-rates may be reduced in expiration to give a more gradual drop in pressure, if desired. However, in most instances, the increased expiratory flow-rates are subjectively comfortable and have no disadvantage.

Pressure breathing can be employed in this apparatus with inspiratory pressure dropping to the atmosphere, if the aim of treatment is to provide increased mean ventilatory pressures, such as are indicated in the treatment of acute pulmonary edema.

With two motor-blower units, E.W.N.P. has been used with negative pressures of 60 mm. Hg. If the swift expiration thus produced is terminated promptly, these higher pressures have little subjective effect except the sensation of rapid expulsion of air from the lungs. Further studies are in progress with plus 40, minus 60 pressures on inspiration and expiration, or a 100 mm. Hg pressure drop which is approximately 13 per cent of an atmosphere. Explosive decompression is achieved in 0.02 seconds. In a patient with a total lung capacity of 5000 cc. after deduction of the dead space, 650 cc. of air would be expelled as a result of gas expansion owing to reduced pressure, indicating a theoretical flow-rate of 32,500 cc. per second for this fraction of the expired air. Studies on this aspect of the use of high negative pressures are in progress.

The directions which are used with E.W.N.P. in the apparatus which has pressure and volume controls are as follows:

1. Plug line cord (I) into outlet. *(A.C. ONLY).*

2. Where abundant secretions are expected, attach trap bottle (B) to outlet from valve. (a) In cases with slight expectoration, bottle is not necessary. The plastic tube is connected directly to the valve outlet.

3. Adjust pressures as follows: (a) Place a rubber cork in open end of bottle trap or outlet adapter to close the outlet of air (near mask A). (b) Turn on both motor switch (F) and valve switch (G) and observe pressures registered on gauge (C). (c) Both pressure control valves (E) are usually closed, to provide plus—minus 40 mm. Hg. If lower pressures are desired, open pressure control valve disks to desired pressure.

4. Adjust inspiration time knob (H) so that the inspiration interval will go from vacuum to pressure in 2.5 seconds. *Time carefully.*

5. Remove cork near mask (A), turn off switches (G and F). Connect plastic connecting tube and mouthpiece or mask (A).

6. E.W.N.P. is now ready for use.

7. Attach mouthpiece or mask to patient. Turn on both switches and operate.

8. One treatment usually consists of five exhalations, "coughs." Patient then breathes normally for one minute to avoid hyperventilation.

9. A total of six to 12 treatments is generally employed at one sitting, *i.e.* 30 to 60 exhalations.

10. Treatment is continued at three-hour intervals, more or less, depending on the individual case.

11. When a new case is treated, unscrew breathing tube, mouthpiece or mask, and outlet adapter. Wash and sterilize chemically with benzalkonium chloride 1:1000, or other solution. Washing with soap and water is most effective and simplest procedure.

12. Unscrew sputum-trap bottle, wash with soap and water. Bottle can be sterilized chemically or by autoclaving, as well as the valve if desired.

SUMMARY

The Exsufflator With Negative Pressure is a device designed to produce expiratory volume flow-rates surpassing those of a normal cough.

A pressure of 30 to 40 mm. Hg above the atmosphere is gradually developed by a motor-blower unit over a period of two to three seconds. By

means of a mouthpiece or mask, this pressure is utilized maximally to expand the lungs and chest. As soon as full chest inflation has taken place, a valve connects the respiratory tract to the negative side of the blower, thereby producing a fall in pressure to 30 to 40 mm. Hg below the atmosphere and expiratory flow-rates of 6000 to 10,000 cc. per second. In a two-motored apparatus, volume flow-rates between 10,000 and 20,000 cc. per second may be obtained.

Expiratory flow-rates of a magnitude of 10,000 to 15,000 cc. per second, more than double those of the natural cough of most patients with respiratory difficulties, are directly responsible for elimination of retained secretions from the tracheobronchial tree in cases characterized by weak or ineffective coughing, including poliomyelitis, bronchial asthma, pulmonary emphysema, bronchiectasis or pulmonary atelectasis from a variety of causes.

The technic of operating the various types of apparatus available is described.

References

1. Barach, A. L., Beck, G. J., Bickerman, H. A., and Seanor, H. E.: Mechanical Coughing: Studies on Physical Methods of Producing High Velocity Flow Rates During the Expiratory Cycle. Tr. A. Am. Physicians **64**:360, 1951.

2. Barach, A. L., Beck, G. J., Bickerman, H. A., and Seanor, H. E., with Smith, W. H.: Physical Methods Simulating Mechanisms of the Human Cough. J. Appl. Physiol. **5**:85, 1952.

3. Bickerman, H. A., Beck, G. J., Gordon, C. A., and Barach, A. L., with Itkin, S.: Physical Methods Simulating Mechanisms of the Human Cough: Elimination of Radiopaque Material From the Bronchi of Dogs. J. Appl. Physiol. **5**:92, 1952.

4. Barach, A. L., Beck, G. J., with Smith, W. H.: The Principles and Technic of Operation of the Exsufflator. Am. Pract. & Dig. of Trt. **3**:733, 1952.

5. Barach, A. L., Beck, G. J., with Smith, W. H.: Mechanical Production of Expiratory Flow Rates Surpassing the Capacity of Human Coughing. Tr. A. Am. Physicians, 1953. Am. J. Med. Sc. September 1953.

6. Seanor, H. E., Beck, G. J., and Ainley, A., with Drimmer, F.: Aspiration Pneumonitis Complicating Poliomyelitis: A Case Successfully Treated by Exsufflation. Ann. Int. Med. **39**:140, 1953.

7. Barach, A. L., Beck, G. J., Bickerman, H. A., and Seanor, H. E.: Physical Methods Simulating Cough Mechanisms. Use in Poliomyelitis, Bronchial Asthma, Pulmonary Emphysema and Bronchiectasis. J.A.M.A. **150**:1380, 1952.

8. Cherniack, R. M., Gordon, C. A., with Drimmer, F.: Physiological Effects of Mechanical Exsufflation on Experimental Obstructive Breathing in Human Subjects. J. Clin. Invest. **31**:1028, 1952.

Basic Procedures in the

Ear, Nose and Throat Operating Room

3 Endoscopy

GLADYS S. BLIZZARD, R.N.
Des Moines, Iowa

Fig. 16: Endoscopic local anesthesia setup.

THE purpose of this series of articles, which began in the November 1953 issue of this magazine, is to guide student and graduate nurses in circulating efficiently in ear, nose and throat surgery. The pictures and notes are basic setups and must be varied for the individual doctor doing the surgery, according to his preferences. Only the procedures most frequently performed at Wesley Memorial Hospital, Chicago, are given; however, these are basic and can easily be used as a guide in other E.N.T. setups, the changes being made according to the operation.

The procedures in an endoscopic operating room are grouped in three classes, direct laryngoscopy, bronchoscopy, esophagoscopy and gastroscopy. All of these procedures are done through the mouth.

Direct laryngoscopy is an examination of the larynx with the aid of a laryngoscope. The laryngoscope is a speculum for the diagnosis and treatment, surgical or medical, of the interior of the larynx.

Bronchoscopy is the examination of the trachea and bronchi with the aid of a bronchoscope. The bronchoscope serves as a specuium for the diagnosis and treatment in cases of disease of the trachea, bronchi and lungs.

Esophagoscopy is the examination of the esophagus with the aid of an esophagoscope.

Gastroscopy is the examination and treatment of diseases of the stomach with the gastroscope.

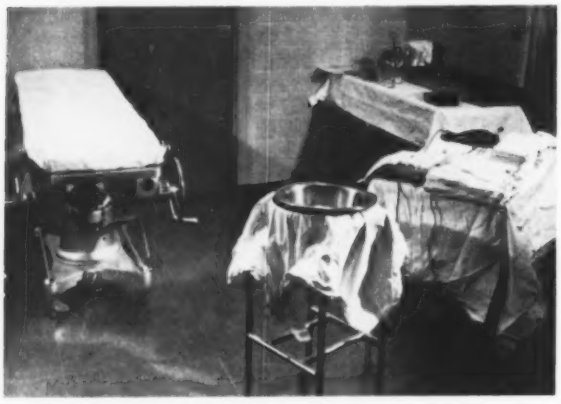
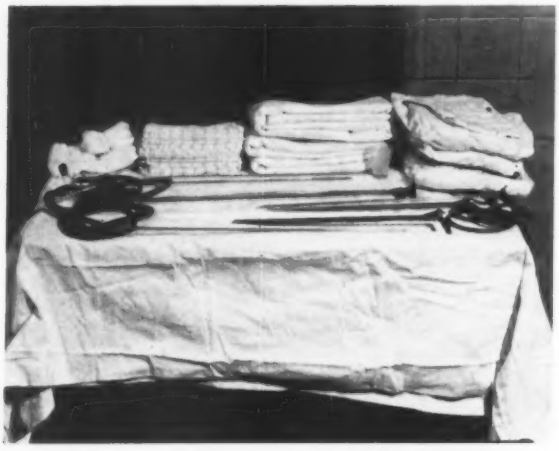


Fig. 17: Endoscopic room setup.

Fig. 18: Bronchoscopy instrument table (left-handed setup).



Bronchoscopy

Equipment (Figs. 16 and 17)

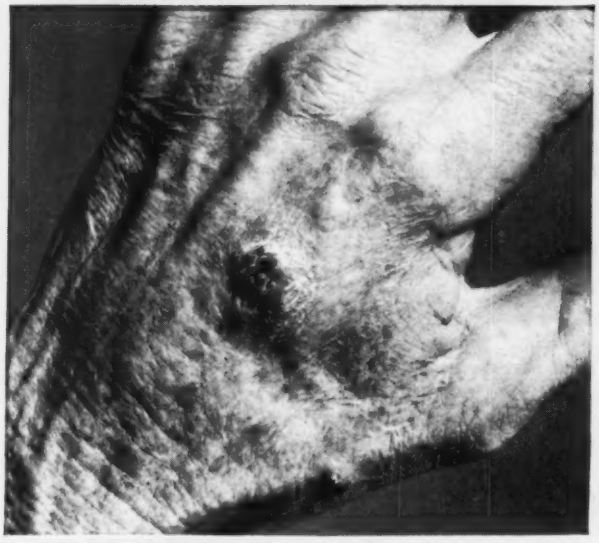
Room setup
- O.R. table
- Back table for linen and instruments
- Mayo table for anesthesia setup
- Battery box
- Single ring stand
- Kick basin
- Stools (one for the doctor to sit on while anesthetizing the patient, one for the doctor holding the head)
- Low platform (to be used as a foot rest by the doctor holding the head)
- Extra table (containing emergency supplies and a pan for soaking instruments)
- Straight back chair (for the patient to sit in while being anesthetized)
- Gooseneck lamp

Sterile Supplies
- E.N.T. pack (containing 2 gowns and hand towels, 2 sheets, 6 towels, 2 pkgs. 4x4's)
- Anesthesia tray
- Single basin (for water)
- Gloves
- Broncho sponges
- Anesthetizing solutions

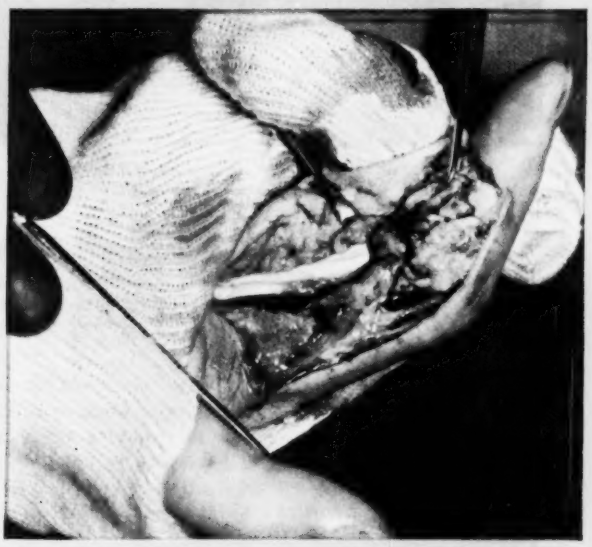
Unsterile Supplies
- Alcohol lamp
- Matches
- Head mirror

Get brilliant photographs...

With the Kodak Master View Camera, 4 x 5, you can be sure of brilliant results . . . sharp, clear, black-and-white photographs—full-color transparencies that sparkle with detail . . . files full of material—close-ups, gross specimens, clinical studies, copies of drawings or charts—for teaching, research, reference and publication.



Hand. Squamous Cell Carcinoma



Tuberculous Tenosynovitis, Pierre J. Le Doux, Chief, Medical Illustration, Veterans Administration Hospital and Center, Wood, Wisconsin.

Rear view of Camera showing revolving back

Get the Kodak Master View Camera, 4 x 5...

Combines light weight, great rigidity and operating flexibility. Has revolving back, rising-falling front, horizontal and vertical swings and other adjustments. Wide choice of Ektar lenses—all color-corrected—all with glass-air surfaces Lumenized. List price—camera, carrying case, holder—$145, subject to change without notice. Lenses extra.

For the full story, see your Kodak dealer or write:

EASTMAN KODAK COMPANY
Medical Division, Rochester 4, N. Y.

Complete line of Kodak Photographic Products for the Medical Profession includes: cameras and projectors—still—and motion-picture; film—full-color and black and white (including infrared); papers; processing chemicals; microfilming equipment and microfilm.

Serving medical progress through Photography and Radiography

Kodak
TRADE-MARK

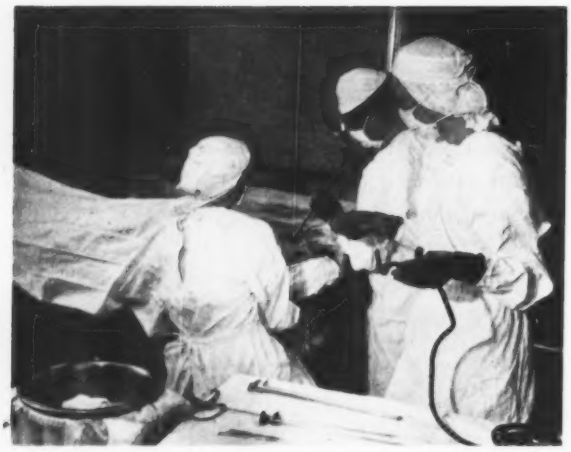


Fig. 19: Endoscopic room setup during the case.

Instruments (Fig. 18)

All the instruments are soaked for 30 minutes in 1:1000 benzalkonium chloride, except the suction tubing, emesis basin, anesthesia spray tips and the collecting tubes; these are autoclaved for 10 minutes.

1. Anesthesia tray (Fig. 16):

Contains liscos, 4x4's, cotton applicators, wooden tongue depressors, Grade A cotton, medicine glasses, syringes, metal applicators, cross-action forceps, malleable tip, anesthesia spray tips, and an emesis basin.

To this tray add the laryngeal mirror.

2. The exact instruments depend upon the size of the patient:

- Bite block
- Laryngoscope and light carriers
- Laryngeal suction tip
- 2 bronchoscopes and light carriers
- 2 light cords
- Bronchial suction tip and tubing
- 3 sponge carriers
- Biopsy forceps
- Forward grasping forceps
- Tissue forceps
- Scissors
- Towel clip
- Atomizing bronchial anesthesia tip

Drape (Fig. 19)

After the patient is anesthetized and moved to the operating table, the scrub nurse drapes the patient by placing one sheet over the patient covering from the chin to the foot of the patient. The doctor then drapes the head with a sterile towel, fastening it with a safety pin.

Room Setup (Fig. 19)

The setup described is for a left-handed doctor. For a right-handed doctor the room setup is exactly reversed.

The patient is anesthetized sitting in a straight chair in the corner of the room. Directly in front of the patient is a stool for the doctor to sit on. To the patient's right is a gooseneck lamp.

At the left of the doctor's stool is another stool containing the tetracaine spray, alcohol lamp, matches and the head mirror for the doctor.

To the left of the straight back chair is the bronchoanesthesia tray on a Mayo table. A medicine glass is filled with 2 per cent tetracaine and placed in front of the tray. The cross-action forceps, malleable tip, laryngeal mirror and 3 cc. tonsil syringes are also placed to the front of the Mayo table.

A kick basin is within reach of the doctor at all times.

The instrument table is placed to the head and to the left of the operating table. It is parallel to the operating table. On the instrument table are the suction tips, sponges, grasping forceps, and biopsy forceps. Gowns and gloves are at the end of the table away from the patient.

The single basin with the hot sterile water is placed next to the instrument table.

Directly at the patient's head and on the shelf under the instrument table is the battery box.

The scrub nurse stands in front of the instrument table and to the left of the doctor.

The only lights in the room are the light of the bronchoscope and the light of the x-ray box.

The overhead light is put out by the circulating nurse as the bronchoscope is inserted.

On a long table on one side of the room are placed the long instrument pan, the emergency drug tray, and the pitcher of hot sterile water. The specimen jars containing formaldehyde and those containing absolute alcohol and ether for papaniculi smears, plus clean glass slides are on this table and ready to be used, if necessary.

It is very important that all light carriers and cords are checked before being soaked, and again when being connected for use.

Procedure

The patient should be brought to the operating room in his robe and slippers. He walks into the room and sits in the corner of the room on the straight backed chair, while he is anesthetized.

The doctor anesthetizes by use of a tetracaine spray and then by dripping the anesthetic into the trachea.

After being anesthetized the patient is moved to the operating table and draped.

The doctor then inserts the bronchoscope and proceeds with the examination. Frequently he wets a 4x4 as lubrication for the bronchoscope.

The instruments used most frequently are the suction and the sponges. He may or may not use the grasping forceps and the biopsy forceps depending on the purpose of the procedure.

In handing the instruments to the doctor, the scrub nurse holds them lightly in both hands with the end that is to be used toward the patient. As the doctor calls for the instrument the scrub nurse guides it toward the opening in the scope, but the doctor inserts it. As the doctor finishes with an instrument the scrub nurse has her hands ready to take it from him to place back on the table.

Sponges are never thrown away after they are used as they are used for specimens. They are placed to the back of the instrument table, after use, in the order in which they were used.

There are usually several specimens for each case, and it is the duty of the circulating nurse to label these correctly and see that they are taken to the laboratory.

Room Cleanup

Clean all the instruments which have been used in solvent solution and dry, giving particular care to the hollow instruments. Use a long brush for this purpose.

Clean all the instruments, including those not used but soaked in the benzalkonium chloride solution, with benzine and ether. A medicine dropper may be used to force these solutions through the instruments.

Take apart and clean all the instruments which come apart. Apply an antirust lubricant to all movable parts.

Check all equipment and resterilize so that it is ready for use again.

Notes and Abstracts

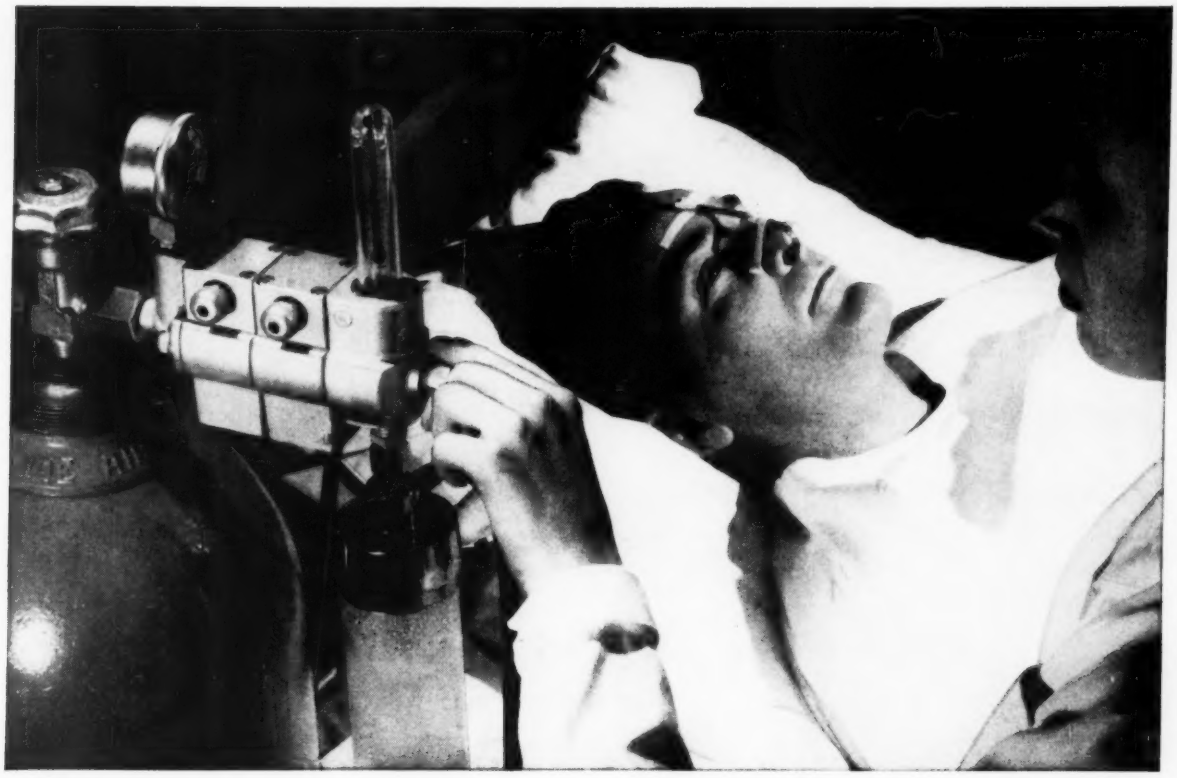
Prepared by the Committee on Pharmacy and Therapeutics
University of Illinois College of Medicine, Chicago 12

EMERGENCY TREATMENT OF COMMON POISONS

POISON	SYMPTOMS	EMERGENCY TREATMENT	SPECIFIC AND SUPPORTIVE TREATMENT
Acids Acetic Hydrochloric Nitric Phosphoric Sulfuric	Burning pain in mouth, throat and abdomen. Whitening of lips and mouth. Intense thirst. "Coffee grounds" vomitus. Diarrhea, weak pulse. Collapse.	Avoid stomach tube, emetics and alkaline carbonates. Give Milk of Magnesia, lime water, milk, egg albumin, and vegetable or mineral oils. Suspension of wall plaster.	Stimulants—caffeine, 0.5 Gm.; atropine, 0.5 mgm. Hold ice cubes in mouth for thirst. Morphine for pain. Treat for shock. External heat. Intravenous fluids.
Acid, Carbolic Phenol Cresol "Lysol" 5 Gms.*	Burning pain in mouth, throat and stomach. Phenol odor on breath. Salivation. Depression. Nausea. Collapse, coma, respiratory failure.	Dilute with oils (olive oil preferred) followed by stomach pump or emetic. 1% magnesium sulfate gastric lavage (2 level teaspoonsful per quart of water). Demulcents.	Stimulants. Morphine for pain. Treat for shock. If patient is comatose begin 10% dextrose infusion intravenously. Artificial respiration. Oxygen therapy.
Acids, Oxalic and soluble oxalates 2 Gms.*	Burning pain in mouth, throat and stomach. Profuse vomiting. Weak pulse. Shallow respiration. Collapse. Tetany of jaw and extremities.	Give Milk of Magnesia, chalk or calcium lactate in quantities of water. Emetics if necessary. If corrosion is slight—gastric lavage with lime water.	Calcium gluconate, 5-10 cc. of 10% solution intravenously. Magnesium sulfate purge. Morphine for pain.
Alcohol (grain) Rubbing alc. Whiskey 250 cc.*	Odor of alcohol. Inebriation. Stupor. Coma.	Gastric lavage with warm water. Warm coffee enema.	Stimulants: Caffeine, 0.5 Gm.; atropine, 0.5 mgm.; aromatic spirits of ammonia. Shock therapy, if in coma. Restraints for excitement or delirium.
Alcohol (methyl) (wood alc.) ("canned heat") 150 cc.*	Hyperemia. Cyanosis, headache, nausea, vomiting, dilated pupils, delirium, blindness, coma.	Gastric lavage with sodium bicarbonate solution, 1%. (Leave 500 cc. of this solution in the stomach) (1% bicarb.— 2 level teaspoonsful/qt. water).	Stimulants. Morphine for pain. Shock therapy. Sodium bicarbonate intravenously.
Alkalies Lye Sodium Hydroxide Potassium Hydroxide Ammonia	Burning pain in abdomen. Mucous membranes soapy and white, then brown and swollen. Bloody vomitus. Feeble rapid pulse. Rapid respiration.	Do not use stomach tube or emetics. Give dilute acids—vinegar, lemon juice, tartaric acid. Follow with olive oil (8 oz.), milk and demulcents.	Stimulants. Morphine for pain. Treat for shock. Intravenous dextrose, 10%.
Alkaloids in general: Aconite Atropine Emetine Ergot Quinine	Differential diagnosis is difficult. Determine if possible specific poison taken.	Give orally solutions of gallic or tannic acid; charcoal, one ounce (2 rounded tablespoonsful). Potassium permanganate 1—1000 (5 gr./pt.) sol. followed by gastric lavage with any of above. Magnesium sulfate purge.	Force fluids. I.V. saline and dextrose immediately. Artificial respiration with oxygen. Shock therapy. If given intramuscularly apply tourniquet to delay absorption.
Arsenic Flypaper Fowler's Sol. Paris Green Rat Poison 200 mgm.*	Headache, vertigo, sensory disturbances. Burning pain in abdomen. Bloody vomitus. Diarrhea ("rice water" stools). Intense thirst. Collapse, coma, or scanty urine.	Gastric lavage with sodium thiosulfate solution or warm water. Intravenous infusion saline with 5% dextrose and 5% sodium bicarbonate. Give BAL (pharmacy) in peanut oil intramuscularly 1 cc. of 10% sol./50 lb. body wt. Repeat at 4 hr. intervals.	Stimulants. Morphine for pain. Treat for shock.
Atropine 1.0 Gm.*	Visual disturbance. Dry throat. Dry flushed skin. Delirium. Rapid pulse, rise in body temperature. Retention of urine.	Routine alkaloid treatment.	Control delirium with phenobarbital, 120 mgm. Cold sponges for hyperthermia. Catheterize for urinary retention.
Barbiturates Phenobarbital "Amytal" "Nembutal" "Seconal" Barbital 1-2 Gms.*	Mental confusion. Ptosis. Sleep. Coma—dilated pupils. Respiratory failure.	Gastric lavage with weak tannic acid solution or potassium permanganate 1-1000 (5 gr./pt.) solution. Charcoal 1 oz. (2 rounded tablespoonsful) by mouth. CAUTION: Picrotoxin, 0.3% sol. 2-5 cc. I.V., or Metrazol, 10% sol. 1-4 cc. I.V. Warm enemas, shock therapy, oxygen, artificial respiration.	Picrotoxin or Metrazol injections—may be repeated at 15 minute intervals until stimulation is evident; complete awakening is not necessary. (CAUTION!) Overdoses of these drugs may cause convulsions. Turn patient frequently to PREVENT PNEUMONIA. Caffeine, I.M., 0.5 Gm. I.V. dextrose, 10-50% for late cerebral edema.
Bichloride of Mercury (Corrosive sublimate) and soluble mercuric salts Mercury vapor 300 mgm.*	Metallic taste. Pain in abdomen. Vomiting. Bloody stools. Irregular pulse and respiration. Collapse, coma.	Give egg white or egg albumin in water. Charcoal in water followed by gastric lavage with sodium thiosulfate sol.	Give BAL in peanut oil intramuscularly: 10% sol. 1 cc./50 lb. body weight every 4 hrs. for 48 hrs. Stimulants. Treat for shock. Morphine for pain.
Boric Acid Borax Perborates 30 Gms.*	Vomiting—diarrhea. Scarlet-red skin. Exfoliation of skin and mucous membranes. Meningismus. Hemo-concentration. Shock.	Gastric lavage with 5% glycerin solution, if taken orally.	Intravenous plasma and lactate. Ringer's solution to promote excretion.
Cadmium Electroplating Ceramic ware "Galvanized" ware	Pain in abdomen. Vomiting (persistent). Diarrhea. Pulmonary symptoms if fumes of heated metal are inhaled.	Morphine sulfate for pain and antimetic effect.	I.V. dextrose-saline. Treat pulmonary cases for pulmonary edema. BAL (pharmacy) 1.0 cc. of 10% in peanut oil for each 50 lb. body weight.

*Minimal adult lethal dose.

(Continued on Page 110)



LINDE *can help you reduce oxygen therapy costs.*

Transfer of oxygen from the cylinder to the lungs of the patient is the most expensive item in oxygen administration. Oxygen that a patient actually receives accounts for only a small percentage of the total cost. But getting oxygen from the cylinder and into the lungs involves the cost of cylinder handling, apparatus amortization, maintenance, and repair, and labor. Wasted oxygen also increases administration costs.

In any given area the price of oxygen does not vary more than a few cents per hundred cubic feet. Therefore, the important savings in oxygen administration are to be made by eliminating wastage, reducing cylinder handling, and cutting the cost of apparatus maintenance and repair through more efficient operation.

Through literature, motion pictures, demonstrations, and personal surveys, LINDE can help you to develop more efficient, economical methods of oxygen administration in your hospital. Consult your LINDE representative about any mechanical problems involving the administration of LINDE oxygen U.S.P. in your hospital.

LINDE AIR PRODUCTS COMPANY
A Division of
Union Carbide and Carbon Corporation
30 East 42nd Street New York 17, N. Y.
Offices in Principal Cities
In Canada: DOMINION OXYGEN COMPANY, LIMITED, TORONTO

The term "Linde" is a registered trade-mark of Union Carbide and Carbon Corporation

POISON	SYMPTOMS	EMERGENCY TREATMENT	SPECIFIC AND SUPPORTIVE TREATMENT
Cocaine 100 mgm.*	Manic stimulation, proceeding to clonic convulsions.	If accidentally injected in an extremity, apply tourniquet to prevent further absorption. Careful injection of I.V. pentothal for convulsions.	Artificial respiration. Oxygen therapy. Cardiac stimulants.
Cyanides Hydrocyanic acid Oil of bitter almonds 100 mgm.*	Cyanide odor on breath. Sudden collapse and death. Smaller doses cause rapid respiration, dyspnea, headache, cyanosis, vomiting, respiratory failure. Skin may be pink.	Amyl nitrite inhalations for 15-60 seconds every 3-5 min. Intravenous injection of 10 cc. of 3% sodium nitrite. Intravenous injection of 50 cc. of 25% sodium thiosulfate.	Stimulants. Treat for shock. External heat. Oxygen-artificial respiration. Sodium thiosulfate gastric lavage with 1% solution.
Fluorides Sodium fluoride Roach powder Sodium fluorosilicate 3.0 Gms.*	Salty taste, salivation. Vomiting, diarrhea. Abdominal pain. Muscle weakness and tremors. Convulsions. Respiratory and cardiac arrest.	Copious gastric lavage with lime water or calcium chloride solution 1%.	Intravenous dose of calcium gluconate 5-10 cc. of 10% solution every hour as needed.
Formaldehyde Formalin	Odor of formaldehyde. Pain in abdomen. Nausea. Vomiting. Weak, rapid pulse. Dyspnea. Anxiety. Vertigo, collapse.	Give orally weak solution of ammonia (ammonium hydroxide) or aromatic spirits of ammonia. Egg whites or milk followed by emetic or stomach tube. Demulcents.	Stimulants. Treat for shock.
Iodine Lugol's Sol.	Pain and heat in throat and stomach, nausea, vomitus may be yellow or blue if starch is present. Intense thirst. Diarrhea (may be bloody). Convulsions. Collapse.	Give sodium thiosulfate in water, 1-10 Gms. Gastric lavage with 1% sodium thiosulfate sol.—2 level tsp./qt. water—or soluble or suspension of starch in water. Egg white and other protein demulcents.	Stimulants. Morphine for pain. Treat for shock. Saline intravenously.
Morphine Potent Synthetics Heroin Dilaudid Racemorphan Methadone Nisentyl	Profound coma. Slowed or Cheyne-Stokes respiration. Contracted pupils.	Gastric lavage. Artificial respiration. Oxygen.	Nalline (N-allyl normorphine) 5 mgm. intravenously every 15 to 30 minutes.
Nerve Gases TEPP DFP Others	Miosis. Salivation, nausea and vomiting. Muscle twitches. Convulsions.	Atropine via syrette 2 mgm.	Atropine in repeated large doses 2+ mgm. Barbiturates for convulsions.
Nicotine "Black Leaf 40" Tobacco paste 60 mgm.*	Excitement, confusion. Restlessness. Abdominal cramps. Depression. Salivation, nausea, vomiting. Prostration. Coma. Respiratory paralysis.	Same as alkaloids.	Stimulants. Artificial respiration. Oxygen therapy.
Petroleum Benzene Gasoline Kerosene Naphtha	Burning in mouth and stomach. Headache. Nausea, vomiting. Convulsions. Collapse—shock.	Gastric lavage with dilute soapy water. Emetics. Oils and demulcents.	Stimulants. Morphine for pain. Shock therapy. Artificial respiration.
Phosphorus Rat or roach paste 60 mgm.*	Garlic taste and odor. Nausea. Cramps. Vomitus and stools may be phosphorescent. Later—malaise, jaundice, collapse.	Copper sulfate by mouth 0.25-0.5 Gm. in 100 cc. of water. Gastric lavage with 0.2% copper sulfate solution, (½ tsp./pint of water). 2% sol. of USP hydrogen peroxide by mouth. 4 oz. mineral oil by mouth.	Do not give absorbable oils, fats or milk. Stimulants. Morphine for pain. Treat for shock. Bicarbonates by mouth. 5% dextrose-saline intravenously. Insulin.
Physostigmine Pilocarpine Mushroom poisoning	Sweating, salivation, colic, vomiting, purging, excitement, coma, shock. Pulmonary edema. Pupils dilated.	Same as for alkaloids.	External heat. Atropine, 0.5 mgm. Stimulants. Oxygen therapy.
Strychnine Nux Vomica 50 mgm.*	Involuntary muscle spasm. Generalized tetanic convulsions. Opisthotonus.	Rapid anesthesia with ether, chloroform or pentothal. Follow with routine treatment of alkaloid poisoning.	Maintain anesthetic depression sufficient to prevent convulsive twitches. Oxygen therapy for depression.

*Minimal adult lethal dose.

C. C. PFEIFFER, Ph.D., M.D.

FREE – a 3 lb. box

to every Hospital in the United States, Canada and Mexico.

..to prove ALCONOX is a MUST! in

- **TERMINAL STERILIZATION***
- **THE LABORATORY**
- **THE OPERATING ROOM**

Terminal Sterilization in the nursery requires special attention in cleaning baby bottles. For cleaning baby bottles Alconox has proven itself Best and Safest in leading hospitals.

Alconox is also the preferred detergent in operating rooms and laboratories.

See for yourself *how* Alconox cleans Better, Brighter and—for only 2½ cents per gallon. See *why* it outsells all other hospital and laboratory detergents.

Fill out Coupon today

ALCONOX INC., 61-63 CORNELISON AVE., JERSEY CITY 4, N. J.

Please send me one 3 lb. can of Alconox, FREE.

*Please send me a copy of your standard procedure on Terminal Sterilization ☐ other literature ☐

Hospital or Laboratory.....

Address.....City.....State.....

Name.....Dept.....Title.....

ALCONOX, Inc.

61-63 CORNELISON AVE., JERSEY CITY 4, N. J.

Small hospital food supervisors are offered

Four Tools for Handling Therapeutic Diets

JANE HARTMAN
Food Service Director
State Department of Health, Baltimore

IN BEAUTY parlor parlance, the matter of special diets has been given "a once over lightly" in many small general hospitals. This seemingly casual treatment may be due to a shortage of dietitians, a shortage which seems greater because of the ever expanding opportunities in dietetics.

It is recognized that hospitals are not buildings, but organizations. If there is one gap in the department head structure, steps must be taken for filling this vacancy. In a small hospital, dietary responsibility is frequently divided three ways. The superintendent or director purchases the food, the director of nurses plans the menus and writes the special diets, and the food service supervisor sets the standards for food preparation and service. A plan of this type is far from ideal, as failure on the part of any member of the team may result in poor food service for patients.

Good food service in hospitals demands that all patients be considered as "special," hence each should have individual attention. The old term "special diet," therefore, is outmoded. In small hospitals, the food service supervisor may not even be aware that therapeutic or modified diets should be patterned as closely as possible to fit the master menu, normal or house diet. All modified diets are based on the general diet but by elimination, addition or method of preparation are *modified* to fill the therapeutic needs of the individual patient.

In her article "What Good Is a Dietary Consultant?" in the September 1953 issue of The MODERN HOSPITAL, Marian C. Jones explains that in Indiana if a hospital does not have a qualified dietitian, it receives periodic consultation from a qualified person in the community or from the consultant of the state board of health. Miss Jones further states that modified diets do not seem to be much of a problem in the small Indiana hospitals because most of them have few such diets. Indiana's solution to this problem is noteworthy.

CONSULTATION SERVICE AVAILABLE

In a number of states, the dietetic associations have assumed responsibility for consultation service to small hospitals and in some instances have prepared diet manuals. For example, a service to small hospitals without dietitians is offered by the Washington State Dietetic Association. Five or six page letters are sent each month to hospitals in the state that desire assistance. One page of these letters is frequently concerned with nutrition or diets.

Because there are not enough trained dietitians to go around, the food service supervisor must have the tools that are part of the equipment of a trained person. Several materials that have been found useful include:

1. "The Master Menu Diet Manual" of the American Hospital Association. This may be obtained by writing the editorial department of *Hospitals*. The 15 modified diets outlined in this book can be used most effectively with the master menu kit. The food service supervisor may need some assistance from a qualified person until she becomes proficient in using the transfer slips and wall cards.

2. "Manual of Applied Nutrition." Dietary Department, The Johns Hopkins Hospital, Baltimore, Janette C. Carlsen, editor. This manual is typical of those prepared by the leading hospitals. The information in the book is well organized, with a table of contents prepared alphabetically. However, the untrained person who uses this manual will probably need a medical dictionary for ready reference.

3. "Handbook of Diet Therapy." Written and compiled by Dorothea Turner for the American Dietetic Association, 1952. This book has proved its usefulness to physicians and dietitians. The food service supervisor will note that each dietary plan has been outlined as an adaptation of a normal diet to ensure an optimum of nutrients. This classification of therapeutic diets in terms of dietetic principles has eliminated the confusion involved in naming diets after doctors or diseases.

4. "Meal Planning With Exchange Lists." Prepared by committees of the American Diabetes Association, the American Dietetic Association, and the diabetes branch of the Public Health Service. This material is available from Health Publication Institute, Inc., Raleigh, N.C. While this booklet was designed primarily for physicians and nutritionists to use to instruct diabetic patients, the food service supervisor in a small hospital may learn to use it for all low caloric diets.

Recipe for a Well Planned Kitchen

(*Continued From Page* 75)
needs and placement. In these recommendations were included:

1. Flow of work.
2. Equipment: kind, size and placement.
3. Storage facilities: refrigerators, broken stock, other supplies, small equipment, such as utensils and containers for holding seasonings.

At this stage of planning, the character of the kitchen was developed. By working with and studying these steps in developing the plans we were all aware of each detail that would be part of, and a contributing factor in, the operation of the new units.

As changes were made in the plans, the architects, the superintendent and dietitian together critically reviewed the revised blueprints. (The patience of the architect will always be remembered by me.)

OPEN INTO MAIN KITCHEN

The plans were for one large unit on one floor, with separate units set up for the preparation of all items which comprise the planned menu. All of these areas open into the center of the main kitchen, separated by half-walls for ease of supervision and also for ease of loading the food on to the food carts. The areas planned were vegetable preparation (vegetable room); vegetable cookery (kettle and steam area); meat preparation (butcher shop, refrigerators); meat cookery with range area; therapeutic kitchen (supplement to house menu); beverage unit (coffee, tea, cocoa); dairy products (milk, butter); salad, dessert, bread; experimental kitchen (recipe testing); ice cream unit, and formula preparation.

Also given careful planning were the offices of the dietitians for ease of supervision and convenience in administrative duties. The administrative areas include a conference room for use in personnel training and patient interview. Careful consideration was also given to the employes in the planning of the restrooms, lockers and showers for their use.

While the architects were busy working on the over-all plans, we were studying each unit relative to flow of work and equipment needed. Equipment engineers were invited to several conferences with the architects to review our recommendations and to offer their suggestions. These conferences were most valuable in our equipment installations. Excellent advice for improved methods of service was given, for they, too, like the dietitian, architect and superintendent, are specialists in their field.

After agreement had been reached on the plans thus far, we listed the equipment preferred: for example, ranges, ovens, deep fat fryers, mixers, tables and all small equipment down to the last knife, the number and size being based on the original estimate of daily requirements. The type and size of revolving bake-oven was decided by actually calculating the loading of ovens for a peak load of rolls and cakes. A similar calculation was made for each installation, including ovens for baking pies and storage cabinets for ice cream.

After we had submitted our estimates, the architect set to work to place all the equipment in a given area. Proper placing of equipment for efficiency, well set-up work areas to minimize lost motion, and selection of equipment for the correct type and in the correct amounts were the major considerations. The installation of the equipment was carefully studied as to ease of cleaning and safety, but equally important was the ease of operation for the employes, such as dull table top finish to decrease light reflection. Working level heights of the equipment, also, were given careful study. At the time of the planning, standard equipment height was 34 inches; our recommendation was 38 inches, but a compromise was reached and the standard height of all our equipment is now 36 inches. With 12 dietitians on the staff we had good opportunity to try out the various heights. The height of the sinks from the floor was raised, thereby automatically raising the bottoms of the sinks, which can be backbreakers if they are too low. Stools with back supports and adjustable legs were purchased for the raw vegetable preparation room. Special tables were planned so that the cleaning of vegetables could be developed as on a production line.

In the beverage section, counters were planned with drops to meet the exact height for loading from the refrigerators to the food carts. In like fashion for coffee (which is to be made in the main kitchen), the height of the platform for holding the unit dispenser is working height, and the counter is the same height so that the dispensers can with one motion be filled and moved over on the cart as it passes the unit for loading.

Another feature of which we are proud is the vegetable preparation room. The storage room for root vegetables and the potato peeler are planned so that the employe who loads the potato peeler travels only a few feet from the storage unit to the peeler. This may seem of minor importance; however, when one considers that we handle approximately 10,000 pounds of potatoes weekly, it will be seen that this convenience cuts the time of preparation by one-third. It is now almost one motion. Likewise, in cleaning vegetables, the vegetables are washed by one employe, advanced to the cleaning table, then to the finishing tables, and finally to the refrigerator for storage. The refrigerator is built with exact measurements to fit the shelved cart used for loading the pans of the finished product. Also, in this unit is a large garbage disposal.

TABLES USED FOR STORAGE

In the meat cookery unit, the worktables are also storage cabinets for the served meats. The meats of necessity must be served ahead when food for 1200 meals is sent out from the kitchens to the divisions in less than 15 minutes. The cabinets under the cooks' worktables are heated containers equipped with shelves, one for each division, to hold the servings for that unit.

In the vegetable cookery department there are no means of holding cooked products. Timers were placed on the vegetable cookers; the vegetables are to be cooked and served *directly* on the carts at loading time. A battery of 5 gallon trunnion kettles was installed for vegetable cookery to avoid cooking earlier than necessary.

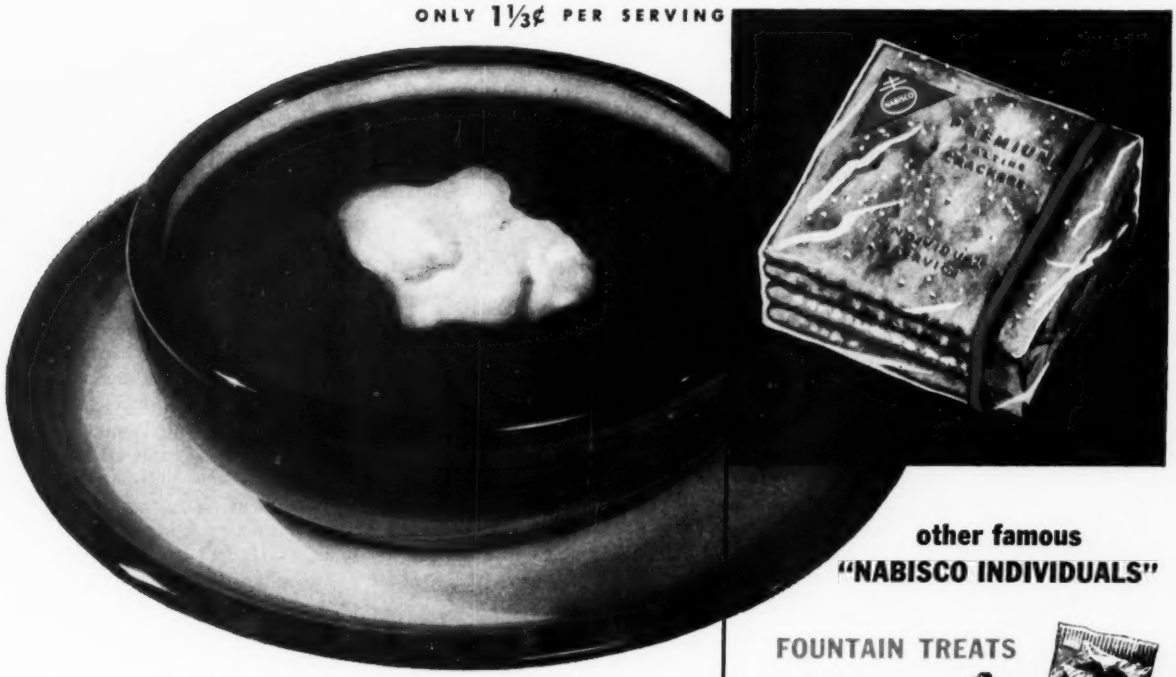
In the special diet area the individual servings of food items which are not found on the house menu and are prepared in this unit are also prepared a little in advance of service. These items are stored in cabinets under the loading table which is placed at the end of this area. One cabinet is refrigerated, the other is a heated container for hot foods; thus as the food carts pass this unit the items are easily

PREMIUM SALTINE CRACKERS

baked by NABISCO

perfect with soups!

ONLY 1⅓¢ PER SERVING



You'll benefit by 6 big advantages when you serve

"NABISCO INDIVIDUALS"

1 Cut handling costs
2 Have less breakage
3 Crackers always fresh
4 Low cost per serving
5 Top-quality crackers
6 Close portion control

SEND FOR FREE SAMPLES AND BOOKLET

National Biscuit Co., Dept. 23, 449 W. 14th St., New York 14, N. Y.
Kindly send free samples and new booklet "America's Home Favorites."

Name.....
Organization.....
Address.....
City.....Zone.....State.....

other famous "NABISCO INDIVIDUALS"

FOUNTAIN TREATS

less than 1⅓¢ per serving

served with ice cream

DANDY OYSTER CRACKERS

less than 2¢ per serving

served with oysters

RITZ CRACKERS

only 1¢ per serving

served with salads

®

NABISCO

loaded on the cart and the hot items are *hot*, the cold items *cold*.

In the beverage area (milk and coffee, dessert and salad, bread), a similar pattern of loading has been set up.

On the return to the kitchen, the empty carts are returned to a cart-stripping room where containers are unloaded on one side and bottles for liquids are unloaded on the other side. A bottlewasher is installed here for washing the bottles. Like the containers, they are unloaded onto especially built carts and taken to the automatic potwasher for washing. It was only after careful study of peak loads and timing that a schedule was outlined which gives the time interval required for washing all containers three times daily in this unit; pots and pans for the production areas are also washed in this unit.

Storage facilities for small equipment were studied and planned as carefully as the equipment itself. Every pan, kettle, or bottle container has a storage place. Bottles, after being washed, are placed in racks planned for each given size used; the racks stack and fit on dollies which, when loaded, are the exact height to be stored under the counter where they will be used. Other equipment has racks designed with the correct shelf height to fit specific containers. Each unit has its own storage area for small equipment.

Much of the guidance has come from factory representatives of this equipment, and they are generous with their time and proud to give assistance. Their suggestions were of great value to us.

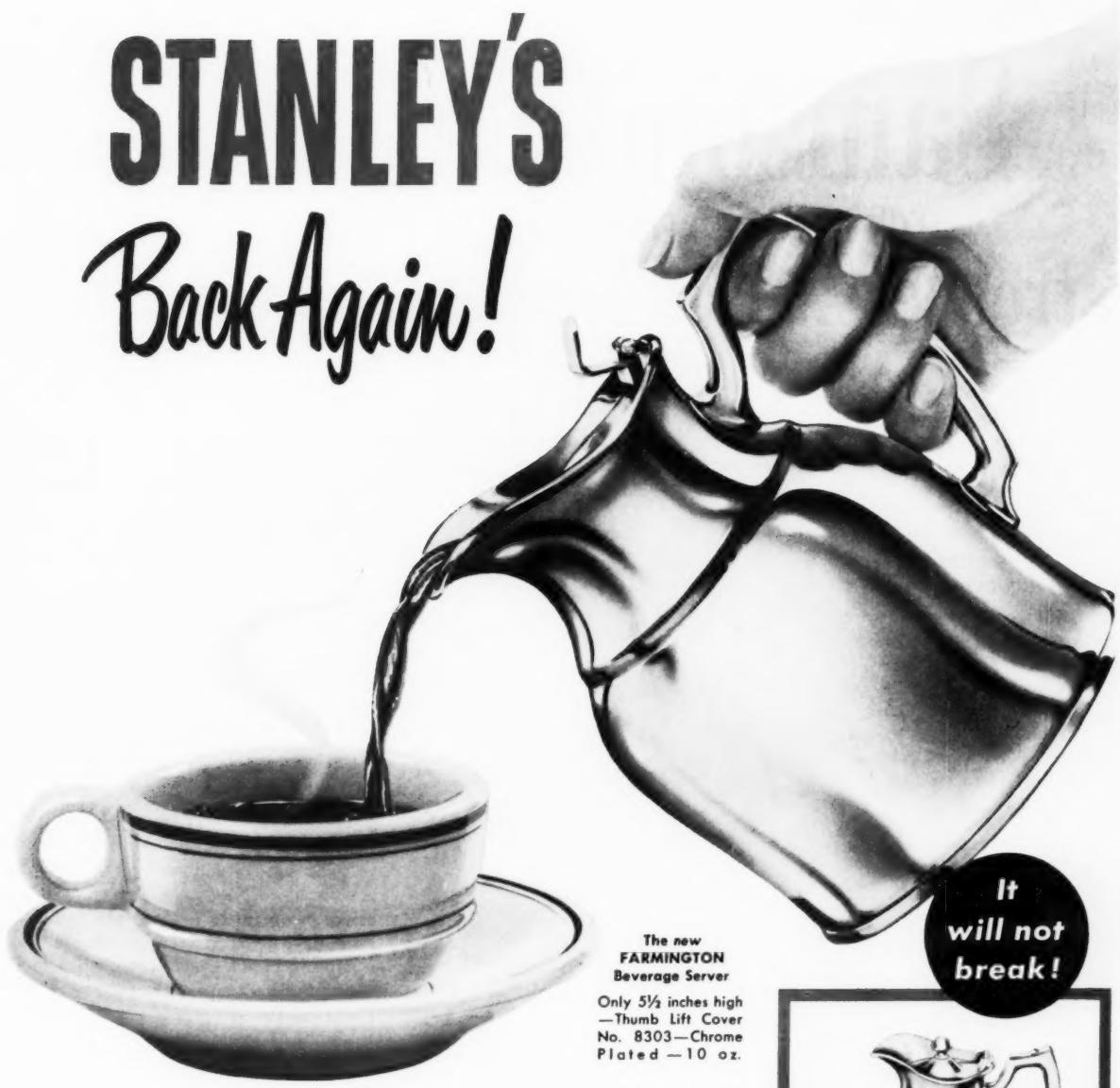
The new construction has two floors; the first floor is the main kitchen which has just been described. The second floor is devoted to personnel food service. These units are connected with an intercommunications system. Here again we studied the flow of work to minimize the time between preparation and service, and we also visited and studied the service and kitchens of two well organized commercial cafeterias and a restaurant planned for table service. Commercial organizations have so much to offer and are willing to give the hospitals assistance in their planning. A commercial organization must make a profit in order to stay in business, therefore its production areas must be carefully set up for efficiency. The restaurants contributed sound advice which was used in our plans. Some helpful equipment hints gleaned here included bun warmers; fruit juice, cocoa and tea dispensers; undercounter sinks, and heated containers.

Sometimes, after one of these field trips, the architects had a perfect right to say "No!" to a change, yet after studying the suggestions, they patiently made another blueprint. Finally, the blueprints were completed, the specifications for all equipment to be installed were written. The architects then asked us to review carefully the written specifications. These were our paper plans and the blueprints from which the contractors work. With this done and the contracts let, one would think we could sit back and wait to move in. How far from the truth this was!

As we purchased the equipment, all items were carefully checked to see if they met the specifications. Many of our storage carts were designed to fit into certain measured areas, therefore all cart measurements were carefully checked. Also, if any recommended changes were made, such as the shortening of a worktable by one or two inches so that a standard instead of a specially built unit could be used,

STANLEY'S

Back Again!



It will not break!

The *new*
FARMINGTON
Beverage Server

Only 5½ inches high
—Thumb Lift Cover
No. 8303—Chrome
Plated—10 oz.

GENUINE STANLEY BEVERAGE SERVERS NOW AVAILABLE—

Yes, once again you can give better service with Stanley —the all purpose beverage server for *hot or cold* liquids! Its nickel silver outer shell and stainless steel interior means Stanley can never break. Wide mouth opening makes it easy to clean and sterilize. By actual test Stanley Servers hold temperatures longer than ordinary servers.

The CHARTER Pattern

No. 316—silver plated 10 oz.
No. 317—chrome plated 10 oz.
No. 326—silver plated 20 oz.
No. 327—chrome plated 20 oz.

For Genuine Stanleys, write **STANLEY INSULATING DIVISION** Landers, Frary & Clark, New Britain, Conn.

which would be more economical, the architect would explain the situation and make a recommendation to us when one was requested. The architects presented their ideas only for our consideration.

All decorations were planned with the help of the architectural firm and other interior decorators. The one request we made here was that the dining room must have a pleasant, friendly atmosphere, so we were given the privilege of doing the planning in the finishing of the walls, floor, draperies, tables, chairs; we presented our ideas and, yes, *asked* the advice of our friends, the architects, on our suggestions.

The contractors also worked closely with the department, particularly where a part of the new kitchen covered the area of the existing kitchen which was in production. Taut nerves were common during some of the work, with steam drills breaking the cement near by, or another drill pounding away at a wall, or the floor broken up and a tunnel dug, around which we walked with care. We learned to work around them, hoping there would be no casualties among the employes.

A sense of humor plus the will to cooperate results in the ability to surmount almost impossible obstacles. Emergencies must be met as they occur. Pipes were installed overhead while food production continued; offices of the dietitians were moved to the main kitchen floor, which added more congestion, if possible, to the already limited floor space; when they were finished, complete with windows cut in the temporary plywood walls, the office resembled a "win, place and show" window at a race track. (I wouldn't have been surprised to have found them so marked by the dietitians.)

Often we felt like the old saying, "water to right of you, water to left of you, and not a drop to drink." Building to the right of us, building to the left of us, and not a place to work!

The day the ground was broken for the new kitchen was a highlight in the life of the dietary department at City Hospital, and as we see the finished structure the hard work is forgotten and we have a real respect for our friends, the architects, the superintendent, and the contractors who built our plans.

Too, we are much the wiser for the experience and grateful to have had a share in the planning.

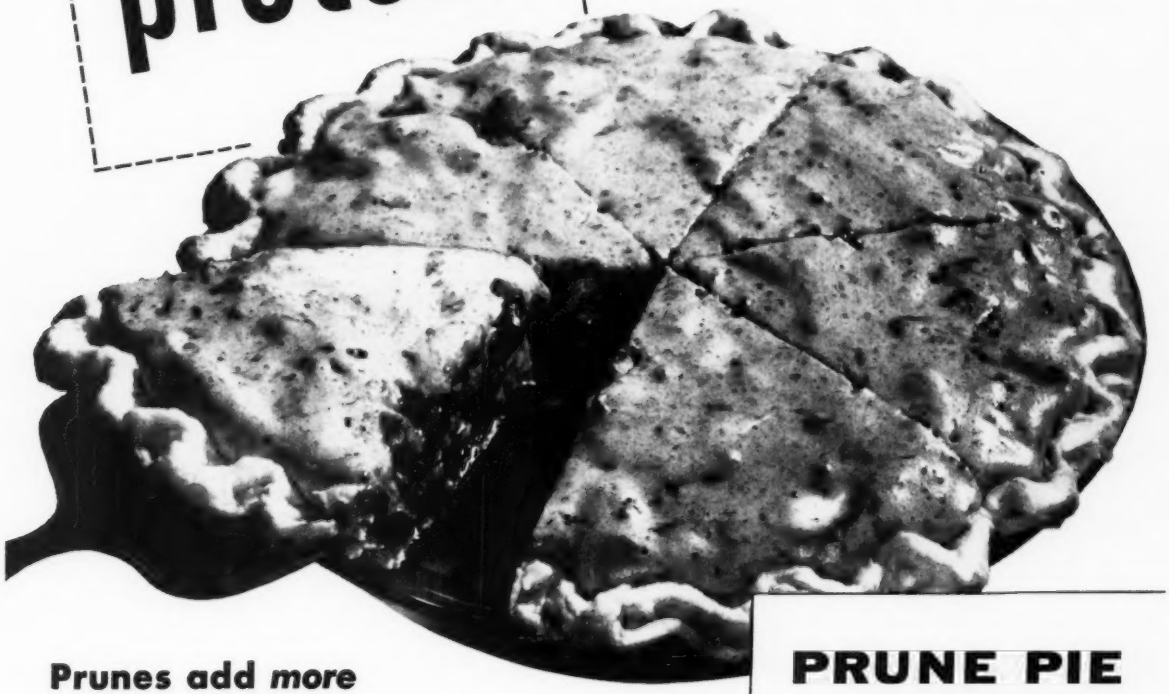
high in protein

YET LOW IN COST!

Here's a dessert that's typical of the way California Prunes help solve special menu needs.

Developed for school-lunch programs, this pie is high in protein—yet it calls for such economical ingredients, you can offer it at a *reasonable price.*

You're sure of *popularity,* too—thanks to the sunny, tangy-sweet flavor of California Prunes!



Prunes add *more* than luscious taste

When your dishes include California Prunes, you provide good eating *and* good nutrition. Here's abundant fruit sugar for energy. Here's one of Nature's finest sources of essential vitamins A and B. Here's protective minerals, too.

So serve prunes *regularly* — in recipes, and right from the package as the ideal between-meals snack.

SPARK UP YOUR MENUS WITH

PRUNES

the California Wonder Fruit

PRUNE PIE
Bavarian

To make four 9-inch pies:

- 5 cups pitted cooked prunes and juice (cooked without sugar)
- 1½ cups lemon-flavored gelatin
- 3 cups sugar
- 2¼ cups dry skim milk powder
- 2½ cups ice water
- ¾ cup lemon juice
- 2 teaspoons grated lemon rind
- 4 baked 9-inch pie shells

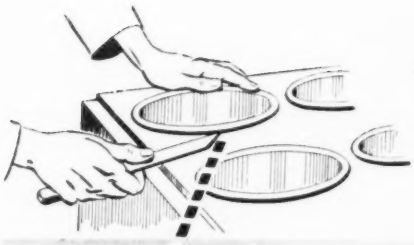
Chop prunes; combine with gelatin and sugar in saucepan. Heat and stir until gelatin is dissolved. Cool until almost stiff. Combine dry skim milk powder, ice water and lemon juice; whip until stiff. Pour on top of prune mixture; beat in slowly along with grated lemon rind. When well combined pour into pie shells. Chill at least one hour.

Mildred Baldridge
Dietitian
Lake View Hospital
Danville, Ill.

Menus for February 1954

1 Banana Scrambled Egg, Roll • Creole Soup Baked Canadian Bacon Escalloped Potatoes Buttered Green Peas Pineapple and Grated American Cheese Pumpkin Custard • Vegetable Soup Sautéed Hamburger and Mushrooms on Toast Buttered Wax Beans Lettuce Wedge With French Dressing Baked Apple	**2** Grapefruit Half Bacon, Toast • Beef Broth Escalloped Turkey Vegetable Casserole Shoestring Potatoes Buttered Broccoli Pear-Cranberry Relish Orange Sherbet • Cream of Mushroom Soup Omelet, Bacon Brown Butter Noodles Buttered Asparagus Tips Spiced Beet Salad Fresh Fruit Cup Cookie	**3** Blended Citrus Juice Pancakes, Sirup • Tomato Rice Soup Braised Shorts Ribs of Beef Parslied Potato Cubes Glazed Carrots Mixed Vegetable Salad, Bleu Cheese Dressing • Chicken Noodle Soup Shepherd's Pie, Potato Edging Buttered Spinach Grapefruit-Orange Salad Frosted Cup Cakes	**4** Tangerine Poached Egg, Toast • Barley Broth Roast Leg of Veal, Dressing Oven Browned Potatoes Mashed Rutabagas Perfection Salad Frozen Pineapple Date Bars • Vegetable Soup Creamed Ham and Peas on Toast Sliced Tomato and Cottage Cheese Salad Fruit Gelatin	**5** Applesauce Scrambled Egg, Roll • Potato Chowder Fried Scallops, Tartare Sauce Whipped Potatoes Buttered Green Beans Coleslaw Apple Pie and Cheese • Cream of Mushroom Soup Salmon Loaf, Caper Sauce Baked Potatoes Stewed Tomatoes Blushing Pear Salad Prune Spice Cake	**6** Tomato Juice Poached Egg, Toast • Cream of Corn Soup Baked Ham Mashed Sweet Potatoes Harvard Beets Fruit Salad Lemon Sponge Pudding • Alphabet Soup Spaghetti and Meat Balls Buttered Asparagus Tossed Salad With French Dressing Whole Peeled Apricots Sugar Cook e
7 Orange Juice Bacon, Toast • Consommé Oven Fried Chicken, Cream Gravy Whipped Potatoes French String Beans Cranberry Gelatin Black Raspberry Ice Cream • Cream of Spinach Soup Assorted Cold Cuts Potato Salad Buttered Peas Sliced Tomatoes Applesauce, Cookie	**8** Prunes Poached Egg, Doughnut • Beef Noodle Soup Yankee Pot Roast Steamed Potatoes Cabbage Wedge Apricot and Marshmallow Salad Gingerbread, Lemon Sauce • Vegetable Soup Baked Liver and Onions Potato in Jacket Stewed Tomatoes Lettuce Wedges, 1000 Island Dressing Fruit Cup	**9** Pineapple Juice Bacon, Toast • Tomato Broth Veal Cutlets Creamed Potatoes Cheddar Carrots Tossed Salad Glorified Rice • Cream of Mushroom Soup Beef and Noodles Buttered Green Beans Snowball Salad Strawberry Shortcake	**10** Grape Juice Scrambled Egg, Toast • Celery Broth Chicken Pot Pie Mashed Sweet Potatoes Buttered Spinach, Lemon Peach Betty • Consommé Hamburger on Bun Potato Chips Buttered Whole Beets Relish Plate Salad Green Gage Plums	**11** Orange Sections Egg, Pecan Roll • Alphabet Soup Roast Pork Mashed Potatoes Buttered Celery and Peas Apple and Grapefruit Salad Raspberry Sherbet • Chicken Soup Ham and Escalloped Potatoes Frozen Mixed Vegetables Spiced Pear Salad Struessel Coffee Cake	**12** Blended Juice Pancakes, Sirup • Vegetable Soup Baked Halibut, Tartare Sauce Chilled Tomatoes Lime Gelatin Salad Chocolate Marshmallow Log • Clam Chowder Creamed Eggs and Mushrooms on Cornbread Buttered Green Peas Fruit Salad and Cottage Cheese Boysenberry Cobbler
13 Sliced Apricot Bacon, Toast • Noodle Soup Porcupine Meat Balls Parsley Cubed Potatoes Buttered Beets Orange and Date Salad, Honey Fruit Dressing Coconut Pudding • Tomato Bouillon Veal Stew With Vegetables Fluffy Rice Frozen Lima Beans Relish Plate Salad Sliced Peaches	**14** Banana Sausage Links, Toast • Fruit Punch Roast Turkey, Dressing Fluffy Whipped Potatoes Broccoli With Hollandaise Sauce Pear and Cherry Salad Peppermint Ice Cream • Vegetable Soup Bacon, Lettuce and Tomato Sandwich Cottage Cheese and Chive Salad Fresh Fruit Cup Heart Cup Cakes	**15** Tomato Juice Egg, Cinnamon Roll • Chicken Rice Soup Ham Loaf Baked Sweet Potatoes Buttered Spinach Pineapple Salad Chocolate Pudding • Alphabet Soup Meat Pie With Biscuit Topping Buttered Peas Tossed Salad With Roquefort Dressing Baked Apples	**16** Grapefruit Half Soft Cooked Eggs • Barley Broth Roast Beef, Gravy Mashed Potatoes Sautéed Parsnips Lettuce Wedge, 1000 Island Dressing Peach Upside Down Cake With Whipped Cream • Cream of Chicken Soup Meat Loaf, Gravy Buttered Potatoes Buttered Beets Coleslaw Fruit Gelatin	**17** Blended Juice Scrambled Egg, Doughnut • Cream of Asparagus Soup Breaded Pork Cutlet Sautéed Hominy Creole Green Beans Waldorf Salad Washington Pie • Beef Noodle Soup Cream Dried Beef on Toast French Fried Potatoes Spinach and Egg Slices Fruit Salad Butterscotch Pudding	**18** Sliced Pears Bacon, Toast • Vegetable Soup Chicken and Noodles Lima Beans Cranberry and Orange Relish Chocolate Sundae • Consommé Hamburger on Bun Buttered Asparagus Celery, Olives, Pickles Royal Anne Cherries Sugar Cookies
19 Grapefruit Juice French Toast, Sirup • Cream of Tomato Soup Salmon Patties Parslied Potatoes Buttered Green Peas Perfection Salad Banana Cream Pie • Pea Soup Creole Macaroni Buttered Green Beans Pineapple and Stuffed Date Salad Vanilla Graham Cracker Pudding	**20** Tangerine Poached Egg, Toast • Alphabet Soup Grilled Salisbury Steak O'Brien Potatoes Quartered Carrots Chef's Salad Frosted Devil's Food Cake • Potato Chowder Hot Roast Beef Sandwich Chilled Tomatoes Lettuce Wedge, French Dressing Apple Crisp	**21** Orange Juice Soft Cooked Egg, Toast • Beef Rice Soup Roast Chicken, Dressing Marshmallow Sweet Potato Mixed Vegetables Frozen Fruit Salad Raspberry Shortcake • Chicken Soup Dried Beef and Noodles en Casserole Buttered Peas Sliced Tomato With Cottage Cheese Angel Food Cake	**22** Grapefruit Sections Bacon, Toast • Consommé Breaded Veal Cutlets Mashed Potatoes Wax Beans and Mushrooms Jellied Pear Salad Cherry Cobbler • Beef Noodle Soup Stuffed Green Peppers in Tomato Sauce Buttered Corn Orange and Apple Salad Brownies	**23** Bananas Scrambled Egg, Roll • Barley Broth Meat Loaf, Mushroom Sauce Oven Browned Potatoes Spinach With Lemon Tossed Vegetable Salad, 1000 Island Dressing Lemon Pudding • Vegetable Soup Ham au Gratin Sandwich Buttered French Beans Celery Hearts Amber Peach Salad Coconut Cup Cakes	**24** Tomato Juice Sausage Links, Toast • Bouillon Swiss Steak Whipped Potatoes Buttered Carrots Pineapple and Cream Cheese Salad Gingerbread • Scotch Broth Turkey á la King on Rice Pudding Toast Sliced Beets Relish Cranberry and Orange
25 Prunes Eggs, Bismarcks • Chicken Noodle Soup Braised Liver, Onions Cream Potato Cubes Escalloped Tomatoes Jellied Orange and Grapefruit Salad Chocolate Ice Cream • Cream of Vegetable Soup Italian Spaghetti Buttered Green Beans Tossed Salad, French Dressing Hot Rolls Fruit Cup	**26** Blended Juice Soft Cooked Egg, Toast • Asparagus Soup Fried Ocean Perch, Tartare Sauce Potatoes Buttered Lima Beans Apricot Jelly Salad Gooseberry Pie • Mushroom Consommé Tuna and Noodle Casserole Buttered Asparagus Applesauce Cinnamon Roll	**27** Kadota Figs Scrambled Egg, Toast • Cream of Chicken Soup Roast Beef, Gravy Buttered Potatoes Buttered Cauliflower Waldorf Salad Rosy Tapioca Pudding • Tomato Rice Soup Meat Balls in Mushroom Gravy Buttered Green Beans and Bacon Mixed Vegetable Salad Boston Cream Pie	**28** Grapefruit Half Bacon, Toast • Beef Noodle Soup Baked Ham Candied Sweet Potatoes Buttered Broccoli Grapefruit and Apple Salad Strawberry Sundae • Vegetable Soup Fruit Plate With Cottage Cheese Assorted Sandwiches Celery, Olives and Carrot Strips Chocolate Cup Cake		

Ready-to-eat or cooked cereals are offered on all breakfast menus.



No Knife-Scraping Needed

. . . BECAUSE THERE ARE NO CREVICES

ORDINARY CONSTRUCTION
showing food conveyor top with crevices around each well.

Seamless, sanitary top eliminates dirt-collecting crevices on all Blickman-Built Food Conveyors

BLICKMAN SANITARY TOP
showing smooth, continuous surfaces where wells meet top deck. Cleaning is simple and quick. There are no crevices where dirt can lodge.

• In ordinary food conveyor construction, wells are separate units, forming crevices where edges are joined to top deck. These crevices form natural traps for food and dirt particles. Usually, adhesions can be loosened only by scraping with a knife or other sharp instrument. Even then, deposits can't be completely removed. It is impossible to achieve real cleanliness. Extra time and labor are required every time the conveyor is cleaned.

Blickman's new seamless top construction, however, permits thorough sanitation. Round and rectangular wells are *actually part of the top deck.* Where edges of the wells meet the top, they form *smooth, continuous, crevice-free surfaces.* There are no recesses where dirt can lodge. Cleaning is quick and easy. Just wiping with a damp cloth keeps the highly-polished stainless steel surfaces bright, clean-looking, sanitary!

Blickman-Built food conveyors alone offer the seamless, sanitary top as standard construction. Investigate this—and other essential features, before you buy your next food conveyor.

SEND FOR *New* VALUABLE BOOK
Describing complete line of Blickman-Built food conveyors, including the widely-acclaimed selective-menu models. Contains detailed specifications.

the *New* Selective Menu Food Conveyor

One conveyor now gives you a great variety of inset arrangements for your selective menus. Interchangeable square and rectangular pans can be placed in the rectangular wells in different combinations. Round wells are used for soup or other liquids; two heated drawers for special diets. There are many other interesting features—write for complete information.

S. Blickman, Inc., 1501 Gregory Avenue, Weehawken, N. J.
New England Branch: 807 Park Sq. Bldg., Boston 16, Mass.

Blickman-Built
FOOD SERVICE EQUIPMENT
EST 1889

See the catalog of Blickman-Built Food conveyors in the Hospital Purchasing File

St. Luke's Hospital has found Three Answers to Communications Problem

A. A. LEPINOT
Assistant Superintendent
St. Luke's Hospital
Cleveland

THE price of a good communication system in any department of the hospital will be amortized in a short time by accrued savings in the reduction of man-hours. The purpose of this article is to present a brief description of the special communication systems which have been installed at St. Luke's Hospital, Cleveland, and a statement of our experiences with them.

A two-way electronic voice communication system between the patient's bedside and the nurses' station has been in operation for more than five years. All adult bed locations in the hospital have been wired for this system and the results are gratifying. It was described in the October and November 1952 issues of The MODERN HOSPITAL, under the title, "The Right Communication System Can Ease the Nurse Shortage."

Certain modifications of the basic patient-nurse, two-way voice system have resulted in communication systems for special areas in the hospital, namely, the delivery suite, recovery room suite, pediatrics department, laboratories, emergency room suite, and operating room suite. Communication systems are applicable to any department of the hospital particularly where the floor plan of the department is of the long, narrow rectangular design. The design of the special communication systems described herein is aimed at three main objectives: (1) to reduce personnel traffic; (2) to increase overall efficiency, and (3) to provide a means of acquiring immediate assistance for the patient in areas of critical or emergency nursing care.

DELIVERY ROOM SUITE

The equipment and the operation of the system installed in the delivery room suite are as follows:

Labor Rooms

1. Patient-Initiated Call. Each of the nine labor bed locations is equipped with the typical patient room signalling device containing a wall plate, a toggle switch, a pull cord assembly (Fig. 1) and the wall speaker-microphone outlet (Fig. 2). The patient switch is off when it is in the "up" position. The switch can be moved to the middle "trigger" position and still not initiate a call. The "trigger" position is the best, for then only a slight pull on the cord is required in order to initiate a call.

Pulling the switch to the "down" position lights a red light on the wall plate beside the patient's bed; a white light in the corridor dome light above the doorway to the labor rooms, a white light on the master unit at the nurses' station, and a white light on the wall outlet in the utility and linen rooms.

2. Answering the Patient-Initiated Call. The call can be answered at the master unit at the nurses' station by depressing the black key directly below the light on the master unit. Then, by depressing the talk-and-listen bar, the person answering the call can address the patient by name and ask the request. By letting the talk-and-listen bar return to the normal "up" position the nurse can hear the patient voice her request. The volume knob on the master unit, once adjusted for proper volume, should remain constant.

When the black key directly below the light on the master unit is depressed, the lights are automatically turned out on the wall plate at the patient's bedside, in the dome light over the doorway to the labor room, on the master unit, and in the wall lights in the utility and linen rooms. This is the automatic reset feature which we incorporated into this system. The patient's signal switch is thus in position for a future call. Should the nurse be near the patient's room and not answer the call from the master unit, she can answer the patient's request, and turn off all lights by manually pushing the patient wall switch from the "down" to the "up" position. It is important when calls are not answered from the master unit that the switch be reset just as soon as the request is taken care of in order to keep the number of lights down to a minimum. The foregoing is entirely similar to the operation of the regular patient-nurse intercommunication system which we have installed on all general nursing divisions in the hospital.

3. Nurse-Initiated Emergency Call. In addition to the patient-initiated call from the labor rooms, there is also an emergency call which is initiated only by the nursing personnel. This emergency feature in the labor rooms consists of two buttons located on the wall speaker labeled "Emerg" and "Reset." Also, on the top of each wall speaker there are two lights which flash when activated, one green and one red (Fig. 2). When immediate help or attention is required in the labor room, the nurse depresses the red "Emerg" button. This turns on the green flashing

CARING FOR WAXED FLOORS IS . . .

A cinch with Sanax

It waxes as it cleans!

REDUCES THE FREQUENCY OF REFINISHING

Sanax was developed to permit frequent cleaning of waxed floors *without washing away the finish* . . . and to eliminate waste in wax and labor. A neutral liquid soap with a wax base, *Sanax* not only quickly removes dirt, oil, and grease, but *leaves a thin film of wax.* In fact, regular use of *Sanax* to machine-scrub or damp-mop waxed floors *actually prolongs the life of the finish,* and thereby reduces refinishing costs on a year-to-year basis.

Like all *Finnell Fast-Acting Cleansers, Sanax* is specially designed for the greater speed of machine-scrubbing, and works as effectually in a *Combination Scrubber-Vac* as in a *Conventional Scrubber-Polisher.* And because *Sanax* is processed from pure vegetable oils, it's *safe for all floors.*

Find out how you can simplify and reduce the cost of caring for waxed floors. *There's a Finnell Floor Specialist nearby* to help you choose the waxes and cleansers that are *exactly right for your needs. Finnell* makes a complete line, so you can depend on unbiased advice. In fact, *Finnell makes everything for floor care!* For consultation, demonstration, or literature, phone or write nearest *Finnell Branch* or Finnell System, Inc., 1401 East Street, Elkhart, Indiana. Branch Offices in all principal cities of the United States and Canada.

- **A mild liquid wax-soap for machine-scrubbing or damp-mopping waxed floors**
- **Leaves a lustrous anti-skid protective finish**
- **Highly concentrated . . . economical to use**

FINNELL SYSTEM, INC.

Originators of Power Scrubbing and Polishing Machines

Everything FINNELL for Floor Care

BRANCHES IN ALL PRINCIPAL CITIES

light on that particular wall speaker-microphone outlet as well as on every wall speaker in all other labor, delivery, utility and linen rooms. With each flash of the light there is also initiated a soft repetitive chime which can be heard throughout the unit to aid in calling attention to the emergency.

Depressing the "Emerg" button also lights a green flashing light in the corridor dome light above the doorway of the particular room so that anyone entering the corridor will be able to go immediately to the location of the emergency. A patient-initiated call that may have been placed prior to the initiation of the emergency call is automatically reset when the "Emerg" button is pressed.

4. Resetting the Emergency Call. When the emergency condition has been taken care of, the nurse resets the emergency call by depressing the black "Reset" button on the wall speaker in the labor room. This turns off the green flashing lights on all wall speaker units in all of the rooms which were activated by this call and the chime is discontinued. The emergency call cannot be reset at the master unit. However, anyone at the master unit may contact the nurse in the labor room through the master unit by depressing the black key below the proper room number and operating the talk-and-listen bar.

Delivery Rooms

1. Ordinary Call. Each delivery room is also equipped with a typical patient room wall speaker with minor additions (Fig. 3). Three buttons are located on each wall speaker in the delivery room: black—"Nurse Call," red—"Emerg," and white—"Reset." On the top of the wall speakers there are two small lights which flash when activated, one red and one green, as on the labor room wall speakers.

When the nurse depresses the black ("nurse call") button on the wall speaker in the delivery room, it lights a white light in the corridor dome light above the doorway to the delivery room, a red light on the master unit at the nurses' station, and a white light in the linen and utility room. This light is for the nonurgent call and there is no chime associated with this call. The call can be answered at the master unit at the nurses' station by depressing the black key directly below the red light on the master unit. Then, by depressing the talk-and-listen bar the person answering the call can ask the nature of the request. By letting the talk-and-listen bar return to the normal "up" position, the nurse in the delivery room can make her request known.

When the black key directly below the red light on the master unit is depressed, the lights are automatically turned out in the dome light over the doorway to the delivery room, on the master unit, and in the utility and linen rooms. The wall unit in the delivery room is thus in position for a future call. The call can also be reset by depressing the white "Reset" button on the delivery room wall speaker. It is important when calls are not answered from the master unit, that they be reset by depressing the white "Reset" button in the delivery room as soon as the request is answered in order to keep the number of lights down to a minimum.

2. Emergency Call. In addition to this nonurgent call from the delivery room, there is an emergency feature. Depressing the red "Emerg" button will light a red flashing light on the particular wall speaker in the delivery room concerned as well as on every wall speaker in all delivery, labor, utility and linen rooms. With each flash of the light there is initiated a soft, repetitive chime heard throughout the unit to aid in calling attention to the emergency.

Depressing the red "Emerg" button also lights a red flashing light in the corridor dome light above the doorway to that particular delivery room so that anyone entering the corridor will be able to go immediately to the location of the emergency. Depressing the "Emerg" button resets the nurse call or ordinary call that may have been placed prior to the initiation of the emergency call.

3. Resetting the Emergency Call. When the emergency condition has been taken care of, the nurse resets the emergency call by depressing the white "Reset" button on the wall speaker in the delivery room. This will turn out the red flashing lights on all wall speaker units in all of the rooms which were activated by this call, and the chime is discontinued. This emergency call cannot be reset at the master unit. However, anyone at the master unit may contact the nurse in the delivery room through the master unit by depressing the black key below the proper delivery room number on the master unit and operating the talk-and-listen bar.

It is entirely possible that under unusual conditions there could be two emergency calls from two delivery or labor rooms simultaneously; therefore, it is necessary for the nursing person-

Fig. 1: Labor room signaling device. Fig. 2: Labor room wall-speaker-microphone outlet. Fig. 3: Delivery room wall-speaker-microphone outlet.

FIG. 1

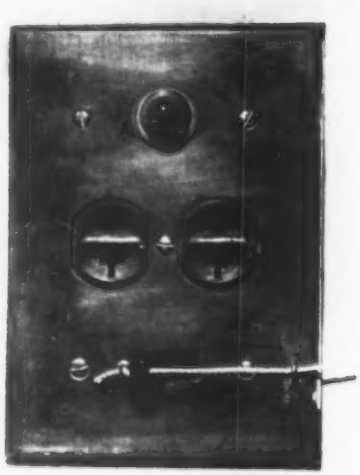


FIG. 2

FIG. 3

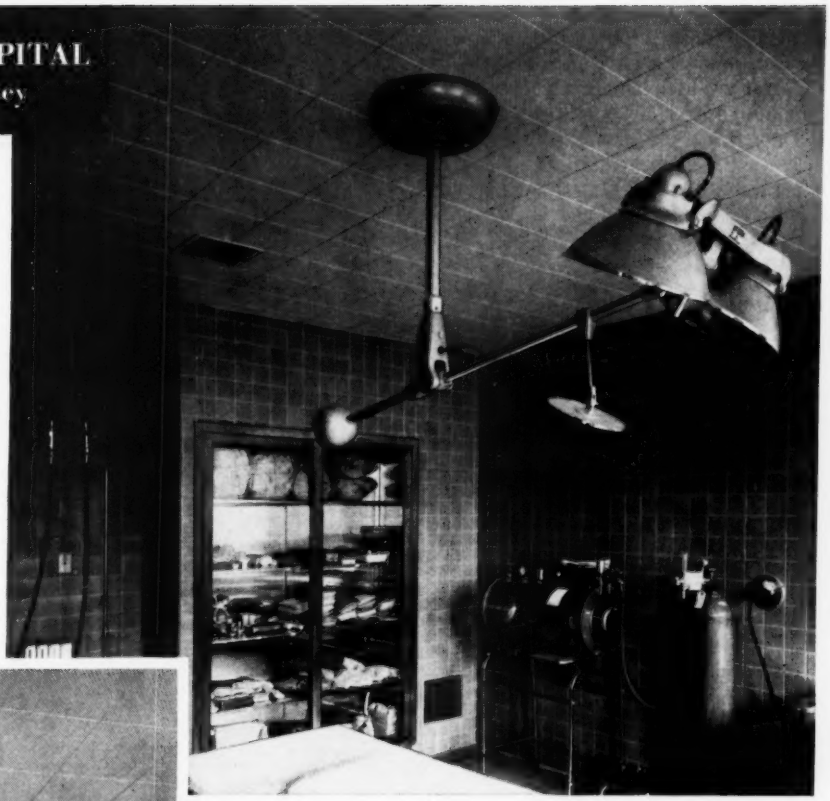
MUHLENBERG HOSPITAL
Plainfield, New Jersey

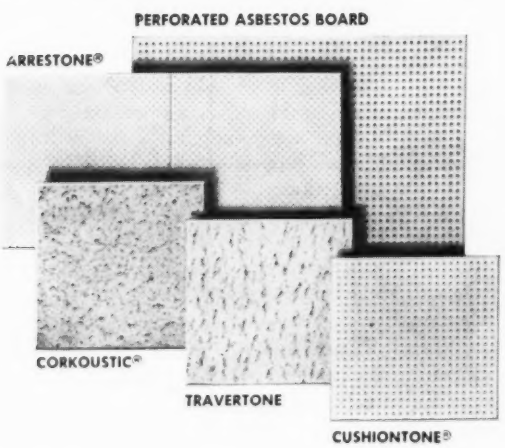
Architect:
Ferrenz & Taylor

Acoustical Contractor:
Wm. J. Scully Acoustics Corp.

Easy to keep clean. Arrestone helps maintain the high sanitary standards necessary in this modern delivery room. Arrestone's white finish reflects light evenly, eliminates annoying glare.

Efficient noise control is especially important in the hospital corridors. Ceilings of Arrestone soak up as much as 85% of the noise that strikes its surface and helps provide undisturbed quiet for patients and staff.





This noise-muffling ceiling is sanitary, too

In planning the new wing of the Muhlenberg Hospital, two important problems were solved by the selection of one acoustical material. The ceilings of Armstrong's Arrestone not only promote necessary quiet but also provide easily cleaned, sanitary surfaces.

Arrestone is a metal-pan acoustical material, backed up with mineral wool pads. Arrestone's smooth, white, baked-on enamel finish can be readily washed or repainted without affecting its high acoustical efficiency. Completely incombustible, Armstrong's Arrestone conforms to the strictest building codes.

Arrestone units are ideally suited for use with recessed lighting, plumbing, and air conditioning. Installed by mechanical suspension, Arrestone conceals all wiring and ducts. And when access to concealed service lines is required, individual Arrestone units can be quickly removed and replaced.

For detailed information on Arrestone and Armstrong's other acoustical materials, see your Armstrong Acoustical Contractor. For your copy of the free booklet, "How to Select an Acoustical Material," write Armstrong Cork Company, 4201 Union St., Lancaster, Pennsylvania.

ARMSTRONG'S ACOUSTICAL MATERIALS

nel to check the corridor for all flashing lights in order to obviate any possibility of overlooking one of two calls.

It is of the utmost importance that lights be turned off as soon as possible after the patient's request or the emergency condition is taken care of. This avoids confusion and enables the most efficient use of the system.

Results

This system has been installed in the delivery room suite for more than a year. The medical and nursing staffs regard the system as an almost indispensable tool in the control of women in labor. Patients feel secure because their calls are answered promptly and immediate assistance is available when needed. The key feature of this system is the emergency button which initiates the flashing light and repetitive chime, thus pin-pointing the definite location where help is needed.

RECOVERY ROOM SUITE

The equipment and the operation of the system installed in the recovery room suite vary from that used in the delivery room system.

There is no patient signaling device. The key feature of the delivery room system is made use of in this area, that is, the flashing light-repetitive chime combination. Simple wall switches and wall lights are installed at various locations in the wards for the use of personnel when immediate assistance is required. Depressing the wall switch initiates a soft repetitive chime which can be heard throughout the unit, calling attention to the emergency. Depressing the switch also turns on a red flashing light on the wall plates in all the wards and also in the corridor dome light above the doorway to the ward where the emergency call was registered. Anyone entering the corridor can easily tell where assistance is needed. In order to reset the call, the switch which is depressed must be returned to the "up" position.

There are four recovery wards of varying capacities totaling 27 patient accommodations. One of the wards is an eight-bed unit for post-tonsillectomy care of children. They are located on both sides of a central corridor. The main nurses' station is located adjacent to the largest ward (10 beds) with a two-way voice communication master unit on the nurses' desk. A single wall speaker-microphone outlet is located in each of the wards just inside the doorway. For ordinary communication between personnel, anyone at the nurses' station can page members of the staff by name by speaking into the master unit. Personnel can call the nurses' station by depressing the switch on the wall speaker-microphone outlet.

Results

The system has been installed in the recovery rooms for about six months. In this area where prompt action is required in the care of patients, the flashing light-repetitive chime feature has been extremely valuable to the recovery room nursing staff. It has been found, however, that the two-way voice system has not been used in this unit as frequently as in other nursing areas. When help is required it is most often of an emergency nature and the emergency switch is used in order to get immediate help rather than the wall speaker-microphone.

The recovery room nurses feel that the special communication system has saved many steps and, most important, has materially improved the care of the patient.

PEDIATRICS DEPARTMENT

The pediatrics department is located on one floor of an entire wing which presents the problems inherent in the long, narrow rectangular design of hospitals.

In selecting a voice-communication system for this unit we decided that it should be limited entirely to the use of hospital personnel. Older children have use of the common pull cord and light system without voice communication. Smaller children have no communication system at their disposal with the exception of the "holler" which is the one most frequently used in this department.

Each of the two nurses' stations is equipped with a two-way voice master unit containing keys for the wall speaker-microphone outlets located in each of the rooms and wards in the two pediatric divisions. The operation of this two-way voice system is the same as that described in the recovery room suite.

There is no special emergency feature installed in this system. A chime paging device is installed and operated by the ward secretary at the nurses' station. The chime is coded; one, two or three to page a nurse's aide, head nurse, or graduate. The chime is heard throughout the unit and the person paged answers from the nearest wall speaker and receives the message from the ward secretary.

Results

The system has been installed in the pediatrics department for about seven months. It is the feeling of the pediatric nursing staff that many steps have been saved in the use of this equipment. The key feature is the chime paging device which locates personnel promptly and expedites the handling of the work on the pediatrics ward.

LABORATORIES

The laboratories are located on one floor of an entire wing which again present the problems inherent in the long, narrow rectangular design. The system installed in this department varies from those already described. The maintenance department put it together by using parts of old communication systems.

This system can be referred to as a "common page-private talk" unit with limitations. There is a master unit located at the laboratory receptionist-switchboard operator's desk. The master unit contains a key for each of six wall speaker-microphone outlets in the clinical laboratory, blood donor room, glassware clean-up room, animal quarters, and two in the corridor.

The receptionist can page anyone on the staff by name by turning the master key to the common page location. The person paged goes to the nearest wall speaker-microphone outlet, depresses the key, and can talk privately with the receptionist. Unless the receptionist has the master unit switch turned to the proper location, *e.g.* animal quarters, the person at the remote wall outlet in the animal quarters will not be heard over the master unit. This represents a disadvantage in the system which is largely overcome by the fact that the wall speakers are selectively located in specific areas, and the person who is to receive a message is generally in that area. In this event the person answers the page and the receptionist turns the switch to the proper location for private conversation.

The aim of this system at the time it was installed was not as a general paging system but rather a system which would draw attention to a specific situation, such as the appearance of an ambulatory patient for a blood count, urinalysis, or to donate blood. In this event the receptionist announces through the master unit into

the clinical laboratory wall speaker that a patient is waiting to be seen. Similarly, in calling the animal quarters, blood donor room, and glassware room, the master unit switch can be set at the proper location for follow-up private conversation. It will be understood in the description of the emergency room system to follow how the disadvantage pointed out in the laboratory's system can be overcome.

Results

The communication system has been installed in the laboratories for several years and has resulted in considerable saving of steps.

EMERGENCY ROOM SUITE

At the time of this writing, remodeling and construction work is in progress to provide an enlarged emergency suite consisting of a total of nine treatment rooms. A somewhat different type of communication system has been selected for this location. Inasmuch as the new emergency rooms will not be completed for several months, we cannot comment on any experience with the operation of this system. However, it may be of interest to describe it briefly.

This system can be referred to as a "common page-private talk" system without the limitations as pointed out in the laboratories' system. The equipment at each location will be identical, consisting of two switches, one light, and a speaker-microphone. The outlets in the nine treatment rooms, corridor, doctors' and nurses' rooms will be wall recessed. The unit at the nurses' station will be desk mounted for easy operation by the ward secretary.

The ward secretary will page anyone working in the area by depressing one of the two switches labeled "common page" and announce the name of the individual being paged. The ward secretary's voice will be heard through all the wall outlets in the entire unit. The person answering the page will go to the nearest wall speaker-microphone outlet and depress the switch labeled "private talk." At the time the "private talk" switch is depressed, the lights on the wall speaker units and also on the nurses' station desk unit will be turned on to indicate to the ward secretary that the page has been answered. The ward secretary will depress the switch on her unit labeled "private talk" and will then be in direct private conversation with the individual paged without any further operation of switches for talk-and-listen.

The lights which are turned on at each wall outlet also indicate to personnel in any room that the page has been answered and that the private talk system is in use. The extreme flexibility to be found in this system, even in addition to that already pointed out, is the fact that a common page and private talk operation can be engineered from any of the wall outlets in the unit just as has been described between the nurses' station and any remote wall outlet. This factor makes the system far superior to the one installed in the laboratories.

This system was designed to locate the proper person from any location in the emergency room suite and to deliver a message. The matter of registering a call for immediate assistance in an emergency has been considered with the point in mind of avoiding a voice communication denoting emergency from the standpoint of patients who might be in other treatment rooms. It would be possible to use a certain code number to denote emergency and then give the room number to lessen the possibility of disturbance to patients. We have not lost sight of the distinct advantage of the emergency flashing light-repetitive chime combination used so successfully in the delivery room and recovery rooms, and it is entirely possible that we will incorporate this emergency feature in the emergency room suite.

OPERATING ROOM SUITE

The proposed system for the operating rooms is on the drawing board. The equipment and operation of this system has been worked out and will be incorporated in the remodeled operating rooms which will be completed within the next six to eight months.

The system consists basically of the same elements as the emergency room system with greater selectivity in the paging device. There will be three switches, one light, and a speaker-microphone at each outlet. One switch will permit the page to go out to the operating rooms, anesthesia department, and doctors' and nurses' rooms; and another switch will permit the page to go out to all service areas, such as the nurses' station, instrument room, sterile supply room, orderlies' room, and doctors' and nurses' room. Each outlet will be identical so that a common page and private talk can be initiated from any location.

There has been discussion as to the desirability of having the speaker-microphone unit suspended over the operating table and it appears possible that this can be done and also incorporate with it a dictation recording device for operative notes. The matter of possible disturbance of the voice to the surgical team has been considered with the conclusion that this would represent little problem.

The flashing light-repetitive chime emergency feature has been discussed for possible installation in this area with no definite decision reached. It was brought up primarily from the standpoint of locating an anesthetist promptly. However, the surgeons felt that when an anesthetist would be required immediately they would rather initiate a common page for him by name through the voice page system. The system will be so constructed that the volume of the voice page will be kept very low.

This system should save many footsteps in the operating room suite and provide greater efficiency and prompt assistance when required in emergency situations.

OTHER DEPARTMENTS

Special communication systems are applicable to other departments in the hospital both where patients are taken care of and in production departments, such as the laundry, central supply, and maintenance department. A patient area in which a communication system has good application is in the outpatient department for use in locating hospital personnel and calling patients from the waiting room.

Communication systems have been developed in other hospitals for use in neuropsychiatric units to provide protection for the nurse or attendants from the psychopathic patients. Specially constructed push buttons can be located in the patients' rooms for the use of nurses or attendants which will turn on a light at the nurses' station and over the doorway to the room, and will also sound an alarm bell or chime which can be heard throughout the unit to summon immediate help when required. All equipment located in the rooms of psychopathic patients can be of special tamperproof construction, making it practically impossible for the patient to render the system inoperable. Once an emergency call is placed the system should be so designed that it is impossible to reset the signal inside the patient's room.

Simmons' **Pictura** *adds the modern touch at Chicago Memorial*

Color, warmth, attractive styling — a far cry from the cold institutional atmosphere of yesterday — find expression in this Chicago Memorial Hospital room, recently refurnished with Simmons' new "Pictura" Furniture.

Here is an entirely new concept in steel furniture, blending attractive color and contemporary styling into smooth unbroken lines that mean easy maintenance. "Pictura" does away with protruding pulls. Self-banded Zalmite tops in harmonizing colors are burn, scratch and mar-resistant.

The 100-room Chicago Memorial, Chicago's oldest private hospital, is refurnishing completely with Simmons. They've found by experience that for durability, ease of maintenance, style and beauty, there is no better value than Simmons furniture and equipment. For modernizing or new construction, call your hospital supply dealer, or write Simmons, for helpful advice.

Above: Chicago Memorial Hospital's newly modernized rooms are equipped with Simmons' "Pictura" furniture, as shown here in Slate Gray with Pale Mist.

Bedside Tables are attractively "picture framed" in the style that gives his furniture its name. Illustrated here in Dove Green with Gray, and with self-banded Zalmite top.

"Pictura" Van-D-Dressers serve as vanity, desk and dresser. Shown here in Mocha with Fawn. Has durable steel top.

Display Rooms:
Chicago 54, Merchandise Mart
New York 16, One Park Avenue
San Francisco 11, 295 Bay Street
Atlanta 1, 353 Jones Ave., N. W.
Dallas 9, 8600 Harry Hines Blvd.

SIMMONS COMPANY

CONTRACT DIVISION

Why this coil makes *Beautyrest* a firmer mattress!

The secret of firm support in a Beautyrest* hospital mattress comes from the much greater number of independently pocketed coils used — nearly three times the number used in the ordinary innerspring mattress. And Beautyrest mattress coils act *independently* because they are not wired together! Result — firmness over the entire mattress surface. Firmness that yields only to varying body weight.

This greater number of independently acting coils also lets Beautyrest conform to the many positions of posture springs without coils buckling or meshing when the mattress is bent.

Another Beautyrest exclusive — ★★★Three-Star Crushproof Border with coils sewn directly to the border which has been reinforced with a heavily upholstered sidewall and inner roll edge. No side pull — edges last as long as the mattress.

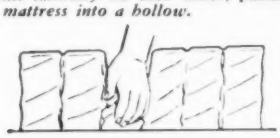
Consider your budget. By comparison, Beautyrest, the mattress built expressly for hospitals, will be your choice. See your hospital dealer, or write Simmons Company.

*TRADE-MARK REG. U. S. PAT. OFF.

BEAUTYREST FOR HOSPITALS MADE ONLY BY SIMMONS

HAND TEST

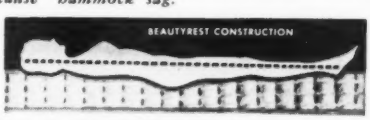
Press down on an ordinary mattress. Although it seems firm, it's because the big, wired-together coils pull laterally on each other, pulling the whole mattress into a hollow.



Now try the same test on a Beautyrest. Only one small, independently pocketed coil (the one you press) yields — the others remain upright to retain a firm mattress.

BODY TEST

The same results occur when the patient lies on the ordinary mattress. Notice how the big wired-together coils pull each other down to cause "hammock sag."

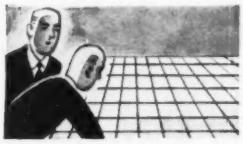


Not so with Beautyrest! The far greater number of small coils act independently to give firm, level support that conforms to body contour.

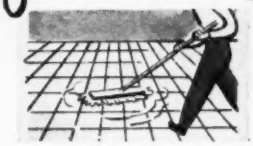
SIMMONS COMPANY
HOSPITAL DIVISION

Chicago 54, Merchandise Mart
San Francisco 11, 295 Bay St.
New York 16, One Park Ave.
Atlanta 1, 353 Jones Ave., N.W.
Dallas 9, 8600 Harry Hines Blvd.

Why make a Safe Floor Slippery?



Hours of labor time are spent in treating expensive floors for slip-resistant beauty.



When an oily floor dressing is chosen that softens the wax film or leaves an oily residue.

A slippery floor condition results that may cause costly accidents.

HIL-SWEEP KEEPS FLOORS SAFE

the new, safe way to daily dust up!

Leaves Floors Cleanly Fresh and Dust-Free

Will Not Soften Wax Film
Leaves No Oily Residue
Won't Decrease Frictional Resistance

Make a Date

with the Hillyard Maintaineer to demonstrate HIL-SWEEP on your floors

There's nothing on the market to compare with Hil-Sweep for daily maintenance. Clear, transparent, clean-smelling, Hil-Sweep picks up dust, leaves a lustre-new look with no harmful effect on your surface treatment. Surface treatment lasts longer. You save labor-time in sweeping and daily maintenance of your floors. Mail coupon below for a demonstration. Advice and help are free.

. . . on your staff not your payroll

Branches in Principal Cities

Hillyard Chemical Co., St. Joseph, Mo.

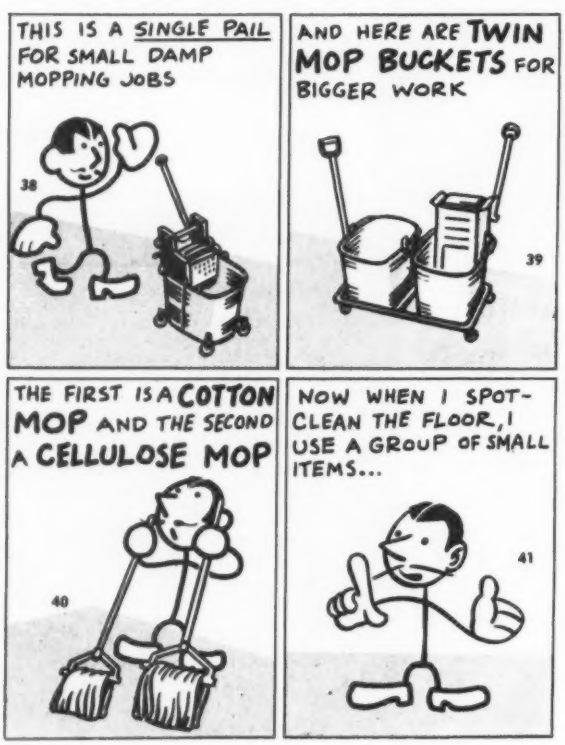
..... Please give me full information on Hil-Sweep.
..... Please have the Hillyard Maintaineer make a Hil-Sweep demonstration on my floors. No charge.

Name..... Title.....
Institution.....
Address.....
City..... State.....

And Here are Other Good Reasons Why HIL-SWEEP is "Sweeping" the Country

- Hil-Sweep is non-injurious to asphalt tile . . . the result of years of research to develop a maintainer that would be safe for daily care of resilient and all other types of floors.
- Rags saturated with Hil-Sweep will not burn, eliminates fire hazard in use or spontaneous combustion of mops in storage. No flash point.
- Contains no emulsified oils, leaves no oily residue to darken, discolor, soften or bleed colors.
- Spray it or sprinkle it on brush, mop or dust cloth.
- Won't load mop. After using simply shake out and brush or cloth is ready to use again. Saves on laundry and dry cleaning bills.
- Imparts a pleasant aroma where used.

Conducted by Alta M. La Belle and Jane Barton



The V. A. Sets Up Housekeeping

TRAINING MANUAL ON WAXING—II

FOUR Housekeeping Training Guides, covering sweeping, mopping, dusting and waxing, have been developed by the Veterans Administration for use in its hospitals. In this issue The MODERN HOSPITAL presents the second section of the manual on waxing. The manuals on sweeping, mopping and dusting have been presented in successive months, beginning in the January 1953 issue of this magazine.—ED.

34. It is a wise waxer who first checks into his equipment. He must know all of the items of equipment that will be needed and he must know and understand how to use each piece of equipment. Much of the preliminary equipment Waxey will require is the same that the other floor-care experts, Sweepy and Moppy, use. However, there are a few items which are used solely for waxing.

35. Here it will be well for the instructor to dwell for a moment on the need for a well-swept floor, before any waxing operations take place.

Unless there is another workman who precedes Waxey in the clean-up operation, it will be Waxey's first responsibility to remove from the floor all litter and loose soil. He will have much need for sweeping equipment.

36. Even though Waxey may already have used his push-broom, the floor may still be soiled enough to require a dust mopping before he begins the waxing or buffing operations.

37. Naturally, the suction or vacuum cleaner is the best possible piece of floor equipment with which to remove soil from the floor before waxing or buffing operations are started. This removes more soil than any other sweeping method does and it also confines the dust and soil and prevents them from recirculating onto the floor and furniture.

38. Waxey wants it understood that a single pail is good only for damp-mopping jobs. If the floor is really dirty, he uses a larger piece of mopping equipment. He often finds it expedient to damp-mop the floor before he buffs it up to a nicer sheen.

39. When there is need for a rather thorough washing job before any of the waxing operations can begin, Waxey uses this twin pail arrangement so that he will have both a container of cleaning solution and a container of clear water for rinsing.

40. If he has a choice, Waxey will never choose a cotton yarn mop for he has a strong preference for the cellulose yarn mop. The cotton mop sheds strings and drops them all over the place.

The cellulose one need not go to the laundry for washing, for the heaviest soils can be rinsed out with little effort.

Moppy especially likes the cellulose yarn mop to use for application of wax to the floor, it lays it on so smoothly. One of its chief virtues is that it is completely *lintless*.

41. Preparation of a floor prior to waxing can be a very time-consuming job, especially if a fellow does not have all of the necessary tools available. Before starting on a waxing job be sure to have all of these items at hand.
42. As long as there is gum chewing, there will be gum wads on the hospital floor. This, therefore, is Waxey's first tool in preparing the floor for waxing. There are usually innumerable gum wads to flip off the floor before sweeping or mopping or waxing can begin.
43. There are usually a number of spots, from spillage or wet trackage or other reasons, which must come up off the floor before Waxey can begin his waxing operations. This cellulose sponge is an ideal tool for these small clean-up jobs.
44. In the small floor-care cleaning operations there are many occasions when a clean cloth will be needed. It is good management to have several clean cloths at hand for whatever needs arise.
45. Many kinds of dirt will not respond to washing procedures unless a small amount of abrasive cleaner is also used. It is well to have a container of this abrasive handy for stubborn cleaning jobs. Remember, the more that is used the greater the need for thorough rinsing.
46. Waxey will always need a small amount of a cleaning chemical. He will adapt the principles which Moppy advocates in types and amounts of soap materials to be used.
47. Along with the cleaning sponge, there will be many occasions when added friction will be needed with which to remove some stubborn soils. The hand scrub brush or the deck brush are handy tools to use for this.
48. Safety is always a factor in the waxing operations. It is important at all times that Waxey be aware of the waxing accident hazards. One of the most important pieces of equipment is the barricade.
49. Before Waxey puts *any water* or *any wax* upon the floor, he makes sure that he will not be responsible for any accidents. He cautiously places the barrier around the area in which he is to work. When he is thus protected he does not have to spend so much time keeping people away from the wet or slippery floor.
50. It is bad enough that patients have to come to the hospital to get their broken bones mended; it would be still worse if they broke bones while in the hospital.

    Not only are the patients likely to have accidents, but staff members and other personnel could very well slip too. Waxey has his eye on a safety award; he dosen't want to be held responsible for anyone's broken bones, their sprains or strains.
51. So, Waxey observes every precaution and keeps everyone off wet or slippery floors. He does something else, too, when he barricades the floor. He preserves his newly applied floor wax until it is good and dry and has been buffed to a nice polish. It looks nicer and lasts longer.
52. The instructor cannot repeat too often the need for clean equipment with which to produce clean results. This is especially true in the waxing operations. When Waxey uses a yarn mop, either cotton or cellulose, it must be immaculately clean, or the newly applied wax will be smudged. Dirt in the wax will be very obvious. Therefore, always start with a spotless, *lintless* waxing mop; it will pay off in better appearance.
53. Either type of mop is serviceable. The cellulose mop, however, has many advantages over the cotton mop. The first advantage is its lintlessness; the second is that it is easier to get clean and to keep clean; the third is its much longer life. It will last from three to six times as long as will a cotton mop. It will not shed strands all over the floor either.
54. The use of a shallow pan when waxing small areas is quite an effective economy. Only a couple of inches of wax need be poured into the pan, to avoid waste. A small cross-bar is built into one side of the pan . . . which serves as a scraper from which the excess wax can be smoothed off.
55. This is Waxey's edger and is used for "edge-waxing" applications only. It is not a tool which will lend itself to large scale "center-wax" applications.

    In the past a lamb's wool applicator was used for this and in many places is still used. The lamb's wool is a perfect material with which to distribute wax evenly over the floor area but it is a hard material to clean. It stiffens and does not lend itself well to the cleaning processes.

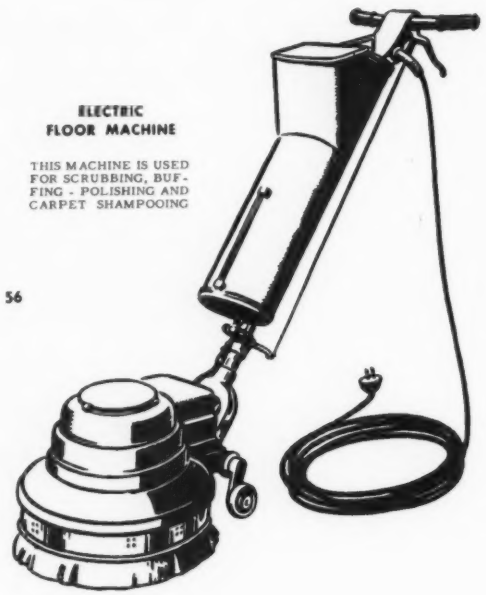
    Waxey uses a block-mop applicator which is made of a cellulose sponge type material, and like all cellulose fibers, it is easy to keep clean. It does not harden up in the cleaning processes like the lamb's wool.

Announcing...

the first Pre-packaged hospital obstetrical dressing

Manufacturers and Distributors of Hospital and Sanatorium Equipment and Supplies

WILL ROSS, INC. MILWAUKEE, WISCONSIN
Atlanta, Ga. • Cohoes, N.Y.



56. This machine is used jointly by Moppy and Waxey for it serves both of their purposes.

Waxey finds it very valuable for scrubbing off old coats of wax, thus preparing the floor for new waxing.

He also finds it a valuable tool with which to perform all of the polishing processes required in good waxing.

57. It is hoped that Waxey will never have floors that are so impacted with dirt that he will have to use this harsh brush-tool. It might prove too sharp and abrasive for soft floors.

It is an effective tool which should be used only when the flooring is of a material that will not be harmed by a wire brush and which has heavy accumulations of stubborn dirt upon it. It is to be used only for the first part of the scrubbing processes and until the stubborn soil is penetrated, not on the flooring itself.

58. The fibers in the Tampico brush are especially chosen for the buffing and polishing brushes, because they are of the best possible consistency for this purpose. The fibers in this type of brush do not lend themselves to "wet work," for they are essentially for dry work. The Tampico brush is always referred to as the "polishing or buffing" brush.

59. The fibers which are used to make the bassine or scrubbing brush are designed for "wet work." The fiber itself has been grown in swampy regions and is constructed by nature to withstand continued wet usage. This is why it is selected for the wet operations of floor care.

60. Both the lamb's wool and the felt polishing pad are used to perform the finishing procedures of the waxing operations. The lamb's wool pad is especially fine to help remove some of the machine swirls and to accentuate the required sheen.

61. The steel wool pad is valuable in many of the floor cleaning and waxing operations. Its one use is to help cut off the small blisters and bumps which form during the application and drying processes of the newly applied wax. This removal of the small wax protuberances provides a much smoother and more attractive end-coat of wax.

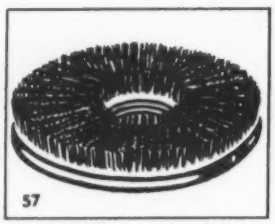
This steel-wooler is also used in the *dry cleaning* processes. It is used to cut off an infinitesimally thin layer of dirty wax before a thin application of clean wax is made.

62. This is an excellent finishing tool for waxed floors. As it is run over the newly waxed floor, its surface heats up with the revolutions of the rotary machine action and serves to give a final smoothing action to the waxed coating.

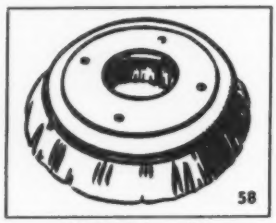
If this special pad is not available to the floor care operator, he can easily improvise a final polishing pad by the substitution of an old wool blanket on the buffing apparatus.

BRUSHES AND PADS

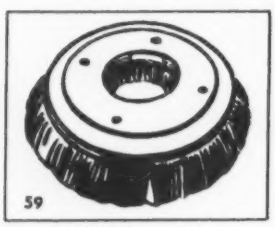
USED ON ELECTRIC FLOOR MACHINE



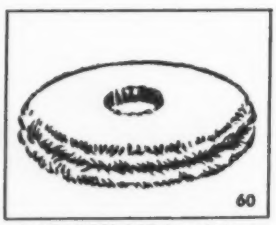
WIRE BRUSH for tough old dirt



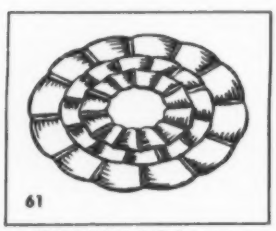
TAMPICO for buffing



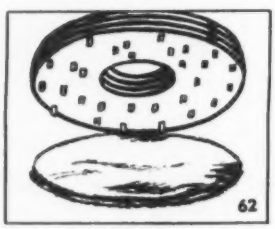
BASSINE for scrubbing



LAMBS WOOL PAD for polishing



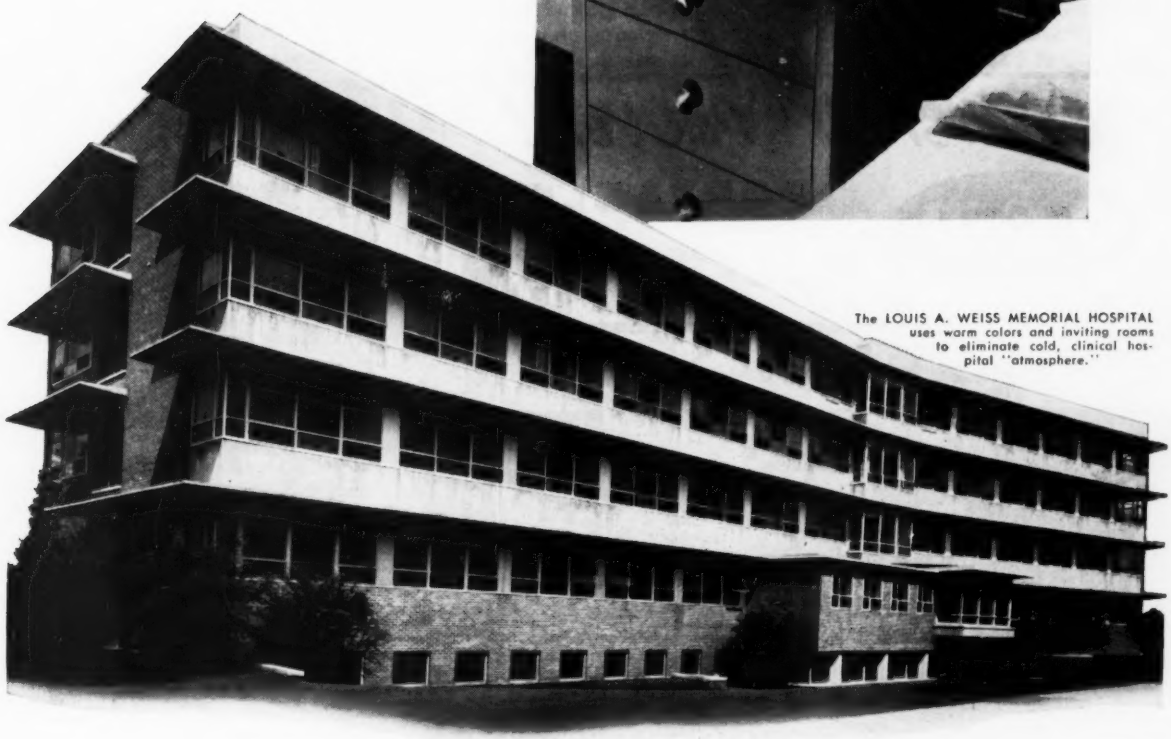
STEEL WOOL PAD for cutting excess wax and dry cleaning



FELT POLISHING PAD for final satin sheen

designed

for today's advanced standards . . .



The LOUIS A. WEISS MEMORIAL HOSPITAL uses warm colors and inviting rooms to eliminate cold, clinical hospital "atmosphere."

NEW LOUIS A. WEISS MEMORIAL HOSPITAL

. . . nearly 100% equipped with VOLLRATH stainless steel HOSPITAL WARE

THIS 3 million dollar general hospital, Chicago's newest hospital located on the northside lakefront, incorporates many innovations in construction, materials and equipment — joining ideas of the future with advancements of today.

Modern hospitals like Weiss Memorial demand durability and functional good looks from all their equipment. This is particularly true in the selection of clinical utensils.

That's why Weiss management specified long-lasting Vollrath stainless steel Ware. This heavy-gauge stainless steel equipment is sturdily built to stand up under the rugged wear of daily use. Quality materials and fabrication give you long range economy and minimum replacement. What's more, seamless, crevice-free construction makes Vollrath Ware easy-to-clean for everlasting brightness . . . certain to conform to rigid sanitary standards.

• • •

See your dealer today. Ask about the advantages of standardizing on Vollrath stainless steel Hospital Ware.

SINCE 1874 — The Vollrath Co — SHEBOYGAN, WISCONSIN

THE VOLLRATH COMPANY
Sheboygan • Wisconsin

Exclusive manufacturers of Vollrath Ware for 80 years — since 1874.

Sales Offices and Display Rooms:
New York • Chicago • Los Angeles

Hospital Credit and Collections

(*Continued From Page 72*)

surance companies and the trend today is to have state laws which enable the hospital to recover its average per patient day cost. Again, the follow-up on compensation cases is time-consuming and is the credit manager's responsibility.

Group Insurance Cases: A large portion of personal responsibility cases carries some form of hospitalization insurance. Holders of such policies and their families, if covered under the policy, have no difficulty in obtaining semiprivate and at times private accommodations, but such insurance pays for substantially less than 100 per cent of the individual bill and it offers only partial protection against hospitalized illness. This creates for the credit manager, in many cases, an unpaid balance, and the patient frequently feels that he has done all he should do. The inadequate coverage of his insurance policy is never questioned; it is always the hospital that is in error. The problem of collecting these balances is not an easy one.

Accident Cases (Emergencies): With the number of automobiles on the road constantly increasing, and with a highway system inadequate to care for the excessive traffic, particularly over week ends, hospitals are faced with an increasing number of emergency accident cases. How can the hospital protect itself from what are, in the majority of cases, medical indigents? A number of states have lien laws which enable them to attach the possible settlement by third parties at a later date. In regard to "later date," it should be noted that these cases often run from one to six years before settlement, and only in the event of settlement can the hospital collect even under a lien law.

Twenty-three hospitals report ability to attach under the lien law. Sixteen report the use of assignments, but under an assignment all are dependent upon the full cooperation of the patient and of the patient's attorney. In the event that the hospital renders care to the occupants of both automobiles, it is obvious that only one group can collect and the other group cannot, except those persons covered as guest occupants. Twenty-seven hospitals report that they are not able to protect themselves in any way and 18 of the 27 report accident cases as a seemingly unsolvable problem regardless of precautions taken and intensive effort to collect.

While the state of Massachusetts has no lien law, and most hospitals have to depend upon obtaining payment direct from patients and/or awaiting final outcome of third party actions, hospitals in Massachusetts have the privilege, under state law, of "welfaring" an emergency or medical indigent case. This assures the hospital of a payment at a statutory rate of $12 per day.

Obviously, it is to the advantage of the hospital to collect in all of these cases direct from the patient wherever possible and to follow all such cases through to their final conclusion on third party action. Accident cases alone require a tremendous amount of follow-up and result in the tying up of

TOPS IN TABLES

by HARD

- CRANK ON TOP
- RIGID SUPPORT FOR TOP
- PROTECTIVE EDGING ON TOP
- BIG VANITY UNDER TOP

EXCLUSIVE DOUBLE
SUPPORT FOR
GREATER RIGIDITY

HARD MANUFACTURING CO.
BUFFALO 7, N. Y. FOUNDED 1874

SEND FOR OVERBED TABLE LITERATURE

Sold Exclusively through Hospital and Surgical dealers

thousands of dollars in temporarily frozen receivables. Accident cases create working capital problems for all hospitals in areas adjacent to highly traveled areas. Oregon not only has a hospital lien law for protection of hospitals and third party cases, but it also has a state motor vehicle accident fund to take care of accounts of indigents. If accident cases continue to increase, combined action on the part of all hospitals will be a "must." The need for full hospital protection on all accident cases *is* a "must." Superhighways are not the answer, for just as many accidents reach the hospitals from the superhighways as from the byways.

SUMMARY AND CONCLUSIONS

Good credit and collection policies are dependent on:

1. *Written Policies.* Clearly defined and written policies should be made available to all staff members and, in part, to the public, such policies to be enforced by the administrator and his assistants.

2. *An Informed Staff and Public.* The reluctance of doctors to discuss total financial costs with patients needs to be overcome. Doctors' charges and hospital rates on obstetrical cases are generally understood, perhaps owing to more frequent contact between doctor and patient. On elective surgery, generally speaking the situation is entirely different. The doctor in most cases neglects to tell the patient, first, what his charges will be; in fact, he seldom tells the patient unless he is asked. He does not inform the patient that there will be a charge for "assisting," nor does he tell the patient that he will have to have an anesthetist, so that when the patient is discharged he receives a statement from the hospital reflecting a remaining balance and shortly thereafter he is presented with three additional bills—from the specialist, assisting doctor, and anesthetist. If any argument ensues the blame seems always to fall on the hospital. More cooperation from doctors in informing patients as to total costs would eliminate misunderstandings.

3. *Competent Personnel:* Many hospitals need to learn that employes who work on credit and collection policies are not "cheaper by the dozen." Adequate compensation is necessary to attract competent and efficient personnel. At the moment it is generally agreed that the rate of pay in the hospital field does not begin to compare with that in business organizations.

4. *The Four Crucial Points of Contact:* Good admitting, consistent follow-up while in the house, good discharging, and an aggressive collection policy after discharge are the four requirements which will result in maintaining receivables at a minimum in order to conserve hospital working capital for much needed reduction of costs or expansion of services.

At the state level the importance of credits and collections in the hospital field is recognized and most hospital assemblies and conventions have panels devoted to credit and collection problems. At the national level the American Hospital Association has been running institutes on credits and collections in the larger cities throughout the country. In all of these discussions credit and collection problems have been beamed primarily at credit and collection personnel. The greater need is for intensive publicity and education directed at trustees, administrators and medical staff members. The combined and continued efforts of all will result in constantly improved credit and collection policies and procedures in the hospital.

Planning the Nurses' Residence

(*Continued From Page* 90)

Group I is built-in equipment which is part of the building and is usually included in the construction contract. Examples are: cabinets, shelves, elevators, work counters, chalkboards, mail boxes.

Group II is major movable equipment, usually large items, having a depreciation of five years or more. These are usually not included in the construction contract and are purchased separately. Examples are: furniture, wheel chairs, cabinet files, microscopes, carpeting.

Group III includes those items which have a life expectancy of less than five years and which cost relatively little. Their selection can be deferred until after the building contract has been awarded. Examples are: syringes, books, linens, brooms, instruments, basins, thermometers.

The selection and purchase of expendable supplies (such as dressings, secretarial supplies, soap, drugs, specimens) may be deferred until after the building contract has been awarded.

The following lists of equipment and supplies should be used only as a check list and general guide for types of items to be considered. Course content, teaching methods, nature of educational program, size of school faculty, and other related factors will influence what constitutes the final equipment list for any individual facility.

"Brands" and design must remain a matter of individual selection and choice, as must the amount, size and type of each item. Placement of equipment by rooms or units will depend upon the building layout, scope of program and the like. Each room must be analyzed and furnished separately to ensure completeness in equipment and supply lists.

Check List of Equipment and Supply for Educational Units

GENERAL (located throughout, as needed for all rooms and areas)

Group I:

Blinds, window
Clock, electric, wall
Elevator
Fire extinguisher
General illumination
Incinerator
Intercommunicating system and telephones
Linen chute
Outlets, electric
gas
water (hot, cold)
Water cooler (drinking fountain)

OFFICES (Administrative, faculty)

Group I:

Bookshelves
Bulletin board
Rod, curtain

Group II:

Cabinets, filing
Carpeting
Chair
Desk
Dictating machine and transcriber
Draperies, window
Duplicating machine
Lamp, desk
Pictures, wall
Table, library
Typewriter

Group III and supplies:

Office equipment and supplies

STORAGE CLOSETS AND WORKROOM (for offices)

Group I:

Cabinet, wall, storage with shelving

Group II:

Chair
Lamp, desk
Worktable

Group III and supplies:

Office equipment and supplies

CONFERENCE ROOM (Administrative)

Group I:

Bookshelves
Bulletin board
Chalkboard, portable
Rods, curtains

Group II:

Carpeting
Chairs
Draperies, window
Lamps
Picture, wall
Table, conference

WAITING ROOM (Adjacent to administrative, faculty offices)

Group I:

Rods, curtain

Group II:

Carpeting
Chairs, easy
Draperies, window
Lamps, table, floor
Pictures, wall
Settee
Table, magazine

CLASSROOMS (LECTURE)

Group I:

Bookshelves
Blinds, window, lightproof
Bulletin board
Cabinet, storage with shelving
Chalkboard
Partition, folding, accordion type
Screen, picture, roll-up

Group II:

Chair, instructor
Chair, tablet arm, student
Charts, demonstration, with cases
Desk, instructor
Illuminator, film (view box)
Picture, wall
Projector, film
Rack, pamphlet
Stand, speaker's with light

SEMINAR ROOM

Group I:

Bookshelves
Bulletin board
Chalkboard
Partitions, folding, accordion type
Rods, curtain

Group II:

Carpeting
Chairs, conference, easy
Draperies, window
Lamps, floor, table
Picture, wall
Rack, pamphlet
Settee
Table, conference

DEMONSTRATION-PRACTICE ROOM

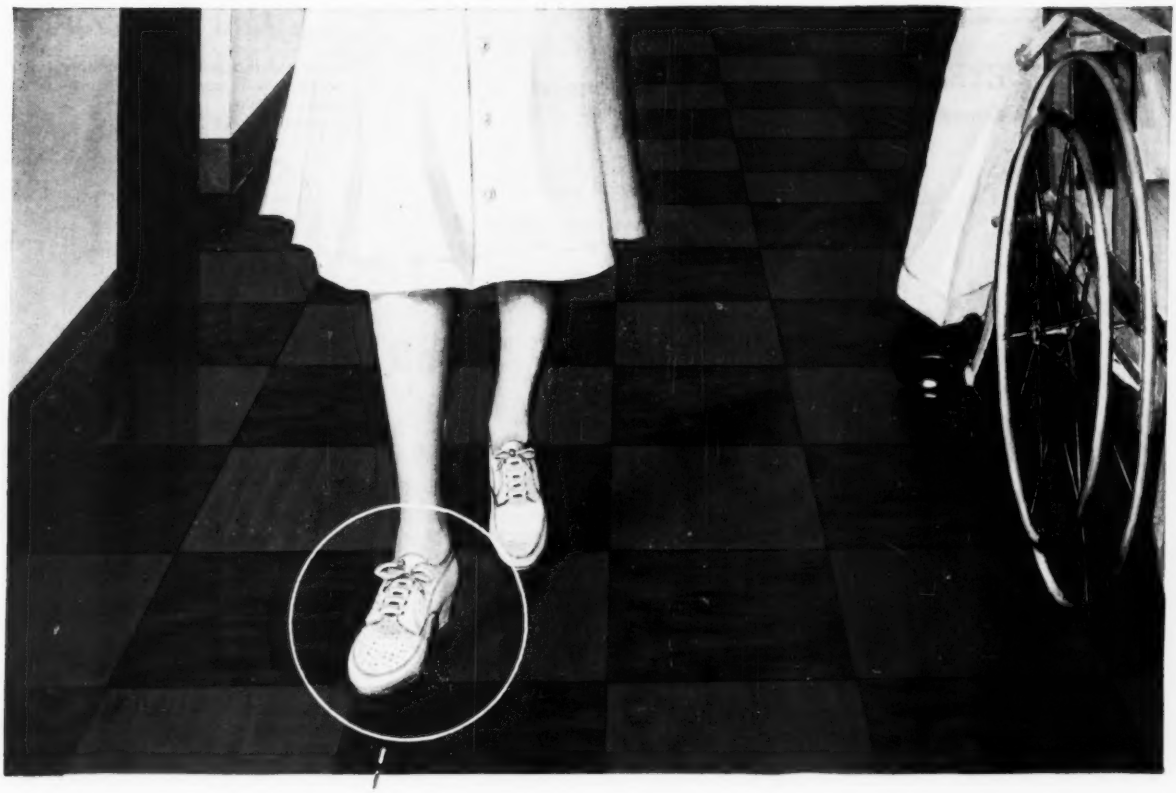
Group I:

Bedpan, washer-sterilizer
Bookshelves
Bulletin board
Cabinet, storage with shelves
Chalkboard
Counter, with cabinets below
Cubicle curtain and rod
Demonstration counter (or table)
Dispenser, soap
Dispenser, towel
Hooks, gown
Lavatory with gooseneck spout, knee or elbow control
Nurse call outlet, and board
Partitions, folding, accordion type
Sink, clinical
Sterilizer

Group II:

Balances and scales with weights
Bassinet
Bed, patient
Can, waste, foot lever
Carriage, dressing
Chair, bedside (patient)
Chair, instructor
Chair, tablet arm (student)
Chart backs
Charts, demonstration, with cases
Clinical mannikin dolls
Cradle, bed
Desk, instructor
Desk, nurses' and chart counter
Hamper, linen
Hot plate, electric
Inhalator
Lamp, bed, therapeutic
Oxygen apparatus
Pad, heating, electric, insulated
Rack, pamphlet
Refrigerator
Scale, clinical
Scale, infant
Standard, irrigating
Stool, foot
Stretcher, wheel
Sphygmomanometer
Stethoscope
Table, bedside
Table, overbed

(*Continued on Page* 142)



There's a layer of safety underfoot with floor wax improved with anti-slip LUDOX®

Here's how "Ludox" adds slip resistance:

"Ludox" is colloidal silica—tough, transparent particles of minute size. The pressure of a footstep forces the hard "Ludox" particles into the softer, larger wax particles. This action absorbs much of the foot's forward-moving energy . . . gives positive traction underfoot.

Extra protection against slipping—so important for patients and busy staff members—is assured with floor wax containing anti-slip "Ludox." The unique snubbing action of the "Ludox" particles heads off a slip before it can start. And because these particles are tough and transparent, wax films are harder . . . have added depth of luster.

All these advantages are added at no sacrifice to the basic properties of high-quality wax. Properly formulated waxes containing Du Pont "Ludox" take a high gloss and have excellent water resistance and leveling properties. It will pay you to investigate these new waxes. Ask your maintenance man to get a sample of floor wax containing anti-slip "Ludox" from your wax supplier. One trial will convince you!

If your supplier doesn't have wax containing "Ludox," write Du Pont, 4147-M Du Pont Building, Wilmington, Delaware.

LUDOX®

COLLOIDAL SILICA

DU PONT

REG. U.S. PAT. OFF.

BETTER THINGS FOR BETTER LIVING . . . *THROUGH CHEMISTRY*

Wheel chair
Worktable

Group III and supplies:

Dressings, surgical
Glassware, clinical
Instruments
Linen, patient, staff, surgical
Medical and surgical supplies
Pharmaceuticals
Printed forms and office supplies
Rubber supplies (*e.g.* gloves, tubing)
Syringes and needles
Trays, assembled clinical sets
Utensils, clinical

PHYSIOLOGY, ANATOMY, MICROBIOLOGY LABORATORY

Group I:

Bookshelves
Bulletin board
Cabinet, display
Cabinet, storage with shelves
Chalkboard
Counters, laboratory, acid resistant with storage space below and knee spaces provided
Counter, demonstration, laboratory, acid resistant, with storage space below
Dispenser, soap
Dispenser, towel
Lavatory with gooseneck spout, and knee or elbow control
Sink, laboratory, acid resistant with drainboard and peg boards
Table, laboratory, without utilities

Group II:

Balances and scales with weights
Bath, water, serological, inactivating
Burner, Bunsen
Cabinets, filing
Cages, animal
Can, waste, foot lever
Centrifuge
Chair, instructor
Chalkboard
Charts, demonstration, with cases
Desk, instructor
Hot plate, electric
Incubator, bacteriological
Kymograph
Lamp, microscope
Microscope
Models, anatomical
Oven, sterilizing
Rack, pamphlet
Refrigerator
Skeleton
Stools, adjustable, laboratory

Group III and supplies:

Animals, laboratory
Chemicals
Coat (gown) laboratory
Culture media
First aid kit
Glassware, laboratory
Instruments, laboratory
Miscellaneous laboratory apparatus and equipment
Reagents
Rubber supplies (*e.g.* gloves, tubing)
Stains
Printed forms and supplies

CHEMISTRY, PHARMACOLOGY LABORATORY

Group I:

Bookshelves (or case)
Bulletin board
Cabinet, display
Cabinet, storage with shelves
Chalkboard
Counters, laboratory, acid resistant with storage space below and knee space provided
Counter, demonstration, laboratory, acid resistant with storage space below
Dispenser, soap
Dispenser, towel
Hood, fume
Lavatory with gooseneck spout, and knee or elbow control
Sink, laboratory, acid resistant with drainboard and peg boards
Still, water
Table, laboratory without utilities

Group II:

Balances and scales with weights
Bath, water
Burner, Bunsen
Cabinets, filing
Can, waste, foot lever
Chair, instructor
Charts, demonstration with cases
Desk, instructor
Hot plate, electric
Rack, pamphlet
Refrigerator
Spectroscope
Table, laboratory

Group III and supplies:

Apron, laboratory
Chemicals
Drugs, pharmaceuticals and biologicals
First aid kit
Glassware, laboratory
Instruments, laboratory
Miscellaneous laboratory apparatus and equipment
Reagents
Rubber supplies (*e.g.* tubing, gloves)
Printed forms and office supplies

NUTRITION LABORATORY

Group I:

Bookshelves (or case)
Bulletin board
Cabinets, display
Cabinets, storage
Cabinets, wall (kitchen)
Chalkboard
Counters, work, kitchen type, acid resistant, with sink assembly, storage space below and knee spaces provided
Counter, demonstration, acid resistant with sink assembly and storage space below
Dishwasher and hood, fume
Dispenser, soap
Dispenser, towel
Fan, exhaust
Lavatory with gooseneck spout and knee or elbow control
Sink, double compartment in counter, with drainboard
Stove, domestic with oven

Group II:

Balances and scales with weights
Cabinet, filing, card
Can, waste, foot lever
Chair, dining, instructor
Charts, demonstration, with chart cases
Desk, instructor
Hot plate, electric
Juicer
Mixer, domestic
Refrigerator
Stools, adjustable, laboratory
Table, dining
Toaster

Group III and supplies:

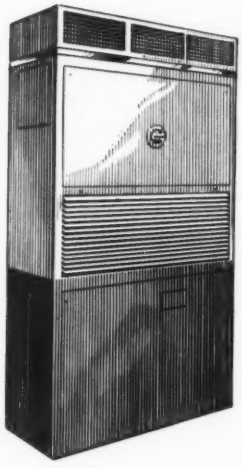
Chinaware
Cutlery
First aid kit
Foodstuffs

(*Continued on Page* 144)

COMFORT PROMOTES RECOVERY...

buy

CHRYSLER AIRTEMP AIR CONDITIONING!



"Packaged" Air Conditioners in nine models, 2 to 15 H.P., meet most cooling needs. Other Chrysler Airtemp products for all systems of air conditioning—a complete line to suit every requirement.

Guaranteed by Good Housekeeping

Discomfort caused by excessive heat and humidity in a hospital makes patients restless and irritable, increases their nervous tension. Through continuous circulation of cool, filtered-clean, moisture-controlled air, modern air conditioning provides a relaxing atmosphere. Patients rest easier, feel better, recover faster. Doctors work more efficiently, experience less fatigue in the air conditioned hospital. And with windows closed against dust and dirt—thanks to air conditioning, it will be so much easier to keep your hospital "hospital-clean."

But get the *best* there is in air conditioning. *Buy Chrysler Airtemp!* "Packaged" air conditioning was pioneered by Chrysler Airtemp in 1937. More Chrysler Airtemp "Packaged" Air Conditioners have been sold than any other make. And only Chrysler Airtemp engineering gives you such important features as the super-efficient, super-quiet Sealed Radial Compressor . . . "Maxi-Fin" Coil for more effective cooling . . . "Airfoil" Grille to direct the air exactly where you want it by means of adjustable vanes . . . greater cooling capacity . . . more compact, space-saving design. Send coupon now for complete details!

Chrysler Airtemp

HEATING • AIR CONDITIONING
***for* HOMES, BUSINESS, INDUSTRY**
Airtemp Division, Chrysler Corporation, Dayton 1, Ohio

MH-1-54

Airtemp Division, Chrysler Corporation
P.O. Box 1037, Dayton 1, Ohio

I'd like to know more about Chrysler Airtemp Air Conditioning.

Name_____

Address_____ Phone_____

City_____ Zone____ State_____

Glassware
Linens
Miscellaneous kitchen apparatus and equipment
Printed forms and office supplies
Silverware
Utensils, cooking

LIBRARY

Group I:
Bookshelves
Rods, curtain

Group II:
Cabinets, filing, card
Carpeting
Chair, library
Desk, librarian, with chair
Draperies, window
Lamps, library
Picture, wall
Rack, periodicals
Table, library
Typewriter

Group III:
Books
Magazines and periodicals
Office supplies

LIBRARY WORKROOM AND STORAGE
(See Storage Closets and Workroom for Offices, page 140)

AUDITORIUM

Group I:
Blinds, window (shades) lightproof
Bulletin board
Curtain, stage and rods
Partition, folding, accordion type
Rods, curtain (window)
Screen, picture, roll-up
Stage

Group II:
Chairs, auditorium
Chalkboard, portable
Draperies, window
Picture, wall
Screen, movie
Stand, speaker's with light
Table, lecture, demonstration

PROJECTION BOOTH, AUDITORIUM

Group I:
Blinds, window, lightproof
Cabinet, storage
Counter, work with storage space below
Stand for projector

Group II:
Projector, film
Stool or chair

COAT (CHECK) ROOM, AUDITORIUM

Group I:
Door, dutch
Rods, coat

Group II:
Stool (or chair)

Group III and equipment
Hanger, clothes

DRESSING ROOMS (THEATRICAL, AUDITORIUM)

Group I:
Lockers, clothes
Mirror, full-length
Rods, clothes (or hooks)

Group II:
Chair
Draperies, window
Lamp, table
Stool, dressing
Table, dressing, with mirror

TOILET, WASHROOM (Auditorium)
(See Toilet, Lavatory and Bathroom, below)

LOCKER-DRESSING ROOMS (Employes')

Group I:
Bulletin board
Lockers
Mirror, full-length

Group II:
Stool, dressing (or chair or bench)
Table, dressing with chair and mirror

REST (RETIRING) ROOM (Employes')

Group I:
Curtain, cubicle with rod
Mirror, full-length
Rod, clothes

Group II:
Bed, Hollywood, mattress
Chair, easy
Desk, writing, with chair
Lamp, floor or table
Table, dressing, with chair and mirror

Group III and supplies:
Linen, bed

TOILET, LAVATORY AND BATHROOM

Group I:
Bar, towel
Dispenser, soap
Dispenser, towel
Fixtures, toilet paper
Grab rail, around tub, showers
Lavatory, with gooseneck spout
Mirror over lavatory
Shelf over lavatory
Shower and dressing compartment with curtains and rods
Tubs, bathing
Watercloset

Group II:
Receptacle, waste, metal, covered
Stool, bath

TELEPHONE BOOTH

Group I:
Bench
Shelf, writing

HOUSEKEEPING ROOM (including linen service)
***Note:* for office see Offices, Administrative Faculty, page 140**

Group I:
Bin, supply
Bulletin board
Cabinet, wall
Counter, with cabinets below
Dispenser, towel
Dispenser, soap
Lavatory with gooseneck spout
Rods, uniforms
Shelving, pigeonhole for laundry packs (student laundry)

Group II:
Cabinet, filing

(*Continued on Page* 146)

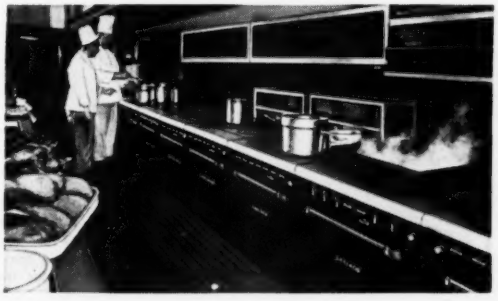
TWO GREAT NAMES...

THE SHERATON-CADILLAC
DETROIT, MICHIGAN
One of the world's great hotels!

Equipped with

GARLAND

THE GREATEST NAME IN COMMERCIAL COOKING!



FAMOUS NAMES IN COMMERCIAL COOKING FROM COAST TO COAST DEPEND ON GARLAND!

Independent surveys prove again and again that Garland Commercial Cooking Equipment has more installations in leading hotels, restaurants, clubs, schools, and institutions than any other make! The reason is simply that men who know, *prefer* Garland quality, durability, dependability, and economy. If you have a commercial cooking problem, see your nearest food service equipment dealer now . . . and get the GARLAND story.

Famous international Chef, Horace Hervilion, of the Sheraton-Cadillac says: "We prepare over 4,000 meals every day! Only Garland Cooking Equipment and gas deliver the kind of top-grade performance and flexibility we require!

The battery formation illustrated includes: Spectro-Heat Hot Top; Open Top; Unitherm Fry Top; Deep Fat Fryer; and Side Fired Broiler. Units available in standard black-Japan or Stainless Steel finishes.

Look for the 45-29 Club pin . . . it's the mark of an expert!

GARLAND

DM PRODUCTS

Heavy Duty Ranges • Restaurant Ranges • Broiler-Roasters • Deep Fat Fryers
Broiler-Griddles • Roasting Ovens • Griddles • Counter Griddles • Dinette Ranges
PRODUCTS OF DETROIT MICHIGAN STOVE CO., DETROIT 31, MICHIGAN
IN CANADA: GARLAND-BLODGETT LTD.—1272 Castlefield Ave., Toronto

Can, waste, metal, foot lever
Chair
Dollies
Fans, electric
Ladder, step
Stool, adjustable
Table, work
Truck, linen
Vacuum cleaner, portable
Waxer

Group III and supplies:

Ash trays
Baskets, maids, wire
Baskets, paper
Buckets, mop
Linens, housekeeping
Miscellaneous cleaning equipment and supplies
Paper, housekeeping supplies
Printed forms and office supplies
Uniforms, maids
Vases

MAIDS', JANITORS' CLOSETS

Group I:

Cabinet, supply
Curb and receptor or service sink
Shelf

Group II:

Truck, mop and water

Check List of Equipment and Supply for Residence Units

GENERAL (located throughout, as needed for all rooms and areas)
(See General, Educational Units page 140)

BEDROOM, RESIDENCE

Group I:

Bar, towel
Bookshelves
Cabinet, medicine (cosmetic) with mirror over lavatory
Intercommunicating system
Lavatory, gooseneck, hot and cold water
Pin-up board
Receptacle, soap
Rods, curtain
Shelf, over lavatory
Telephone jack

Group II:

Bed, Hollywood, with mattress
Chair, easy, study
Desk, study
Draperies, window
Dresser, with mirror
Lamp, desk, table, floor
Picture, wall
Table, end, occasional

CLOSET, BEDROOM

Group I:

Cabinet, with lock
Hooks, clothes
Rack, shoe
Rod, clothes
Shelving, storage

LOUNGE, INFORMAL DORMITORY

Group I:

Bookshelf
Rods, curtain

Group II:

Chair, easy, straight
Draperies, window
Lamp, floor, table
Picture, wall
Radio
Settee
Table, card, with chairs, end, occasional

KITCHENETTE, INFORMAL, DORMITORY

Group I:

Bar, towel
Cabinets, wall, kitchen type
Counter, work, kitchen type with storage space below
Dispenser, towel
Receptacle, soap
Sink, double compartment in counter with drainboard
Stove, domestic type with oven

Group II:

Can, waste, metal, foot lever
Chair, dinette
Mixer, domestic
Refrigerator
Stool, kitchen type
Table, dinette
Toaster

Group III and supplies:

Chinaware
Cutlery
Foodstuffs
Glassware
Linens, kitchen
Miscellaneous kitchen apparatus and equipment
Silverware
Utensils, cooking

BATHROOM-TOILET FACILITIES (RESIDENCE)

(See Toilet, Lavatory and Bathroom, page 144)

TRUNK AND LUGGAGE STORAGE ROOM

Group I:

Compartments, individual trunk and luggage
Racks, luggage

LAUNDRY AND PRESSING ROOM (STUDENT PERSONAL USE)

Group I:

Board, ironing with sleeve board
Counter, work, with lavatory (hot and cold water) and storage space below
Dispenser, towel
Racks, drying, clothes
Receptacle, soap
Rods, clothing
Tray, laundry, double compartment

Group II:

Chair, straight
Drier, electric, domestic type
Hot plate, electric
Iron, electric, hand
Stool, adjustable
Washer, electric, domestic type
Table, work

SEWING ROOM (STUDENT PERSONAL)

Group I:

Board, ironing, with sleeve board
Dispenser, towel
Dispenser, soap
Lavatory with gooseneck spout
Mirror, full-length, three-wing
Rods, clothes

Group II:

Chair, straight
Form, dressmaker, adjustable
Iron, electric, hand

(*Continued on Page* 148)

Lamp, sewing
Sewing machine, motor driven
Table, cutting

Group III and supplies:

Receptacle, waste

LOBBY RECEPTION, WAITING ROOM

(See Waiting Room, Administrative and Faculty, page 140)

RESIDENCE OFFICE, RECEPTION AND ADMINISTRATIVE

Group I:

Bookshelves
Bulletin board
Cabinet, storage
Counter, lift top and gate front
Intercommunicating system
Mail boxes, student, with lock
Outlet, electric
Rod, curtain
Vault

Group II:

Cabinet, filing, letter card
Chair
Desk
Dictating machine and transcriber
Draperies, window
Duplicating machine
Lamp, desk
Picture, wall
Table, library
Typewriter

Group III and supplies:

Office equipment and supplies
Register, guest, student

CLOSET, STORAGE, RESIDENCE OFFICE

Group I:

Counter, wall, storage with shelving
Rods, clothes
Shelving

MAIN LOUNGE, RESIDENCE

Group I:

Bookshelves
Partitions, folding, accordion type
Rods, curtain

Group II:

Carpeting
Chairs, easy, occasional
Draperies, window
Lamps, floor, table
Piano
Picture, wall
Radio
Settee
Table, end, extension, occasional
Television

PARLORS, RESIDENCE

Group I:

(See Main Lounge)

Group II:

Carpeting
Chair, easy
Draperies, window
Lamps, floor, table
Picture, wall
Settee
Table, occasional

SERVING PANTRY, MAIN LOUNGE

(See Kitchenette, Informal, Dormitory, page 146)

RECREATION ROOM

Group I:

Bulletin board
Cabinets, storage, with shelves
Partitions, folding, accordion type
Rods, curtain

Group II:

Chairs
Draperies, window
Lamp, floor
Picture, wall
Table, occasional

Group III and supplies:

Dispenser, soft drink
Miscellaneous
entertainment and recreational apparatus and equipment

SUN DECK, ROOF GARDEN

Group I:

Light, outdoor type
Outlets, electric, outdoor
Storage area

Group II:

Chairs, garden type
Tables, garden type

Group III and supplies:

Boards, sunning
Miscellaneous
entertainment and recreational apparatus and equipment
Umbrellas, garden type

HOUSEKEEPING

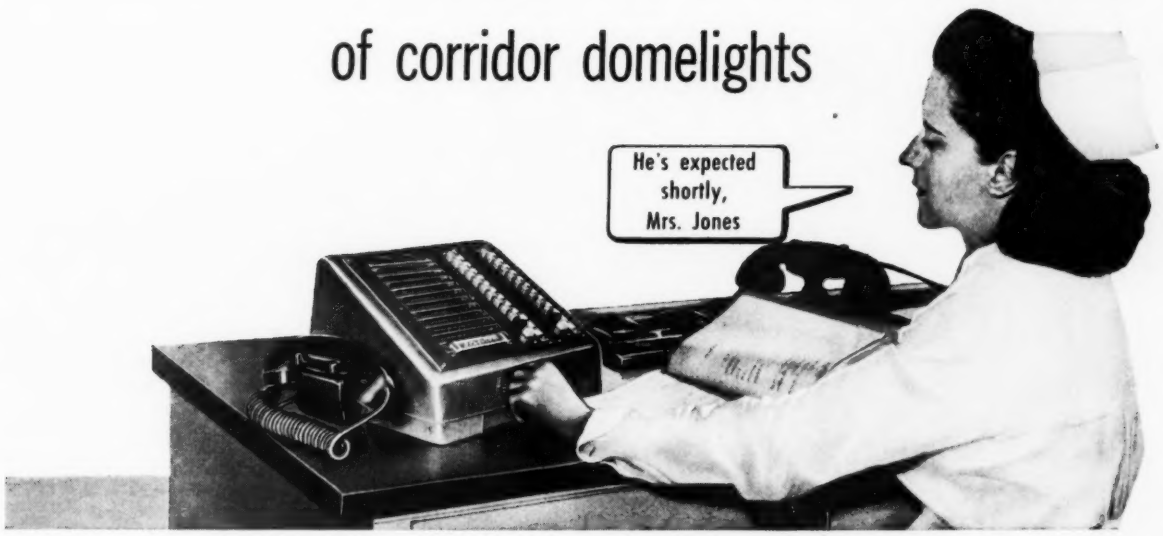
(See page 144)

Add **AUDIO** easily

to your present

VISUAL nurse call system

of corridor domelights



Executone's DEPENDABLE Audio-Visual Nurse Call System Cuts Foot Travel in Half!

Easily and quickly added to your present visual domelight system, Executone frequently uses *existing* conduits or raceways—providing you with a *modern* Audio-Visual Nurse Call System! All accomplished with no interruption of service during installation!

Many hospitals—old and new—are discovering the economy and efficiency of Executone's Audio-Visual system. More patients are handled with *less effort, in less time!* One hospital reports that Executone has reduced operating costs 8% per bed. *It is an invaluable aid in relieving the nurse shortage.*

By pressing a bedside button, the patient activates signals at three locations—chime and light on nurse's control station, corridor domelight, buzzer and light on duty stations. The nurse presses key to reply . . . Executone's Call System may be installed complete, added to existing domelight systems, or installed without domelights.

FOUR MORE *Executone* SERVICES

1. ***Radio-Sound Distribution System*** provides patient with entertainment programs through individual "pillow speakers".

2. ***Doctors' Call System*** locates doctors instantly, anywhere in the hospital.

3. ***Bed Occupancy Monitor***© alerts nurses when a "bed restricted" patient tries to get out of bed.

4. ***General Administrative Intercom*** coordinates activities between departments and individuals.

Executone

HOSPITAL COMMUNICATION SYSTEMS

MAIL COUPON TODAY!

EXECUTONE, INC. Dept. A-8
415 Lexington Ave., New York 17, N. Y.
Without obligation, please let me have information on the following:

- ☐ Audio-Visual Nurse Call System
- ☐ Radio-Sound Distribution System
- ☐ Bed Occupancy Monitor© ☐ Doctors' Call System
- ☐ General Administrative Intercom

Name_____ Title_____
Hospital_____
Address_____
City_____ State_____

In Canada: 331 Bartlett Ave., Toronto

Criterion Is Medical Need

(*Continued From Page* 61)

Some of the failure of general hospitals to undertake the care of the long-term patient has resulted from the fiction of average costs per patient day. Administrators have inaccurately based estimates of cost per patient day for long-term care on their actual costs per patient day for short-term care. This manner of thinking denies the concept of avoidable costs while at the same time it ignores the principle of marginal costs in connection with unavoidable costs. There is no reason why any segment of the cost of long-term care given in a unit contiguous to a general hospital should be higher than the costs of the same quality of care given in a similarly designed unit remote from a general hospital. There are definite reasons why certain segments of the cost of both types of care would be lower because of the advantages of increased spread of overhead and many other items of unavoidable costs.

The confusion as regards costs of long-term care if provided in a general hospital results from our faliure to recognize that one institution under the same roof can render two different types of service. This can, of course, be done only if the facilities are designed and staffed for different types of care.

General hospitals would make a grave mistake to attempt the care of long-term patients in facilities planned for short-term patients. This would result in decreasing the total of beds available for short-term patients; in inefficient and expensive care, and in inadequate care for the long-term patient. The plant layout for long-term patients should be designed to meet the special needs of those patients while at the same time taking advantage of the fact that they do not have many of the special needs of the short-term patient. Such planning requires the best knowledge of all those familiar with the care of the long-term patient. An important consideration that must be kept in mind is that the auxiliary and service areas to be used in common in the care of short-term and long-term patients must be carefully evaluated and brought into balance with the needs of both types of care.

The provision of the needed hospital facilities for long-term care will require tremendous capital funds. Such facilities simply cannot be inferior to those of the modern general hospital. Thus far little interest has been demonstrated in the provision of those funds. The usual sources of capital funds for the general hospitals have been weakened by the heavy taxation policies of the past couple of decades and there is serious doubt that they can maintain the flow of capital funds necessary to meet the replacement needs of the existing general hospitals. Hill-Burton programs offer our greatest hope. To date, however, most states have given little Hill-Burton support to long-term facilities. They have largely concentrated their attention on the smaller rural hospitals for acute care. If any sizable portion of the construction funds needed for adding long-term beds to the general hospital plants are to be obtained through the Hill-Burton program it will be necessary that the pattern be changed. If this is to be the channel through which some of the funds are to be obtained it is important also that all those interested in the problem of hospitalization for the aging give the strongest possible support to continuing the ap-

propriations for the Hill-Burton program.

Hospitalization for the long-term patient is no new problem. We have hesitated to come to grips with it because we preferred to hide it in worn-out, oversize dwellings in deteriorating neighborhoods. The question now facing doctors and hospitals is the best method of handling the problem. Many will argue that the general hospital should not shoulder this responsibility. At the same time strong voices from within and without the hospital field are urging general hospitals to take over the functions of public health agencies, and also to extend their responsibilities to include the home care of the patient. The only answer that makes sense is that the general hospital must accept fully, and accept first, those responsibilities it is better qualified to handle than is any other agency within the community. Because of the resources that are integrated with the general hospital it is logical for the community to expect that the general hospital will make those resources available to all who need integrated medical care. The indications of need for such care are medical and the use of any other criterion, such as the length of stay or age of the patient, represent a failure in the general hospital's responsibility to its community.

New Yardsticks

(*Continued From Page 61*)

of social medicine is that unifying force. The social workers in the division must interview all applicants for admission to all of the three main patient services of the hospital: the clinic, the inpatient facilities, and home care, at the same time the physical examination is being done by the doctor. The time to assist the patient in finding the type of medical care best suited to him is at the time of admission when the doctor and social worker can jointly evaluate, each in his respective field, the patient's needs. After the decision is reached, the doctor and social worker follow the patient as the other medical and ancillary services are brought into the actual treatment of the patient. Education and orientation of the house staff to the medical-social factors in disease enables the division of social medicine to project its philosophy of service throughout the entire hospital. A unit chart must be used by all departments in order to assure the continuity of care and decrease the possibility of expensive and unnecessary duplication of services.

It is, of course, not only the social and medical services which are oriented to the care of the aged; a key department in any patient care is nursing. On home care the already existing visiting nurse service is used. Frequent conferences among the social worker, the doctor, and the nurse either at the hospital or at the visiting nurse center assure each member an informed and important place on the medical team. Administrative aids such as a standard referral system and a nurse coordinator assure the smooth flow of orders and interpretations.

In the hospital itself, a great deal of the bedside care is given by trained practical nurses, graduates for the most part of our own school. During their training a special course of six hours of instruction and practice is given on the care of the aged and chronic patient both in the hospital and the home. The student practical nurse is also assigned to the home care pro-

gram for three weeks where, under the supervision of a trained supervisor and the visiting nurse service, she actually cares for patients in their homes.

Do not make the mistake of thinking that because elderly patients have a longer average stay the use of ancillary services in the hospitals will decrease. In spite of the fact that these patients stay a little over four times as long as the acutely ill patients, they still require per patient treated five times as many electrocardiographs, more than four times as many laboratory tests, and three and one-half times as many x-ray films. This situation is bound to exist as the hospital limits admissions to those who really need inpatient care.

Add to the foregoing figures increased utilization of ancillary services by the preventive and therapeutic clinics and home care department, and the utilization of ancillary services increases without a corresponding increase in bed capacity.

Almost every other department in the hospital will be affected by the admission of the elderly ill. The percentage of special diets will increase as high as 40 or 50 per cent of the total patient meals. Surgery becomes more complicated because preoperative selection is more delicate and postoperative care is more difficult. Physical therapy and radio therapy are other departments which will have to key their services to the care of the aged.

Many hospital administrators will not agree with this pattern of services. It seems to commit their institutions to too wide an area of service, to overextend their already strained resources, and appears to complicate their problems, increase their costs, and, above all, play hob with their previous short average stay.

There will have to be a revolutionary change in the attitude toward the average stay of a patient in the institution. We Americans tend to place undue reliance on a few statistical terms. A striking example of this is the national preoccupation with batting averages and earned run averages for our favorite baseball players. We seem to feel that, if we know these few facts, nothing else is important concern ng the player; we do not realize, of course, that the high batting average may not necessarily reflect the ability to hit in a pinch or play with the team.

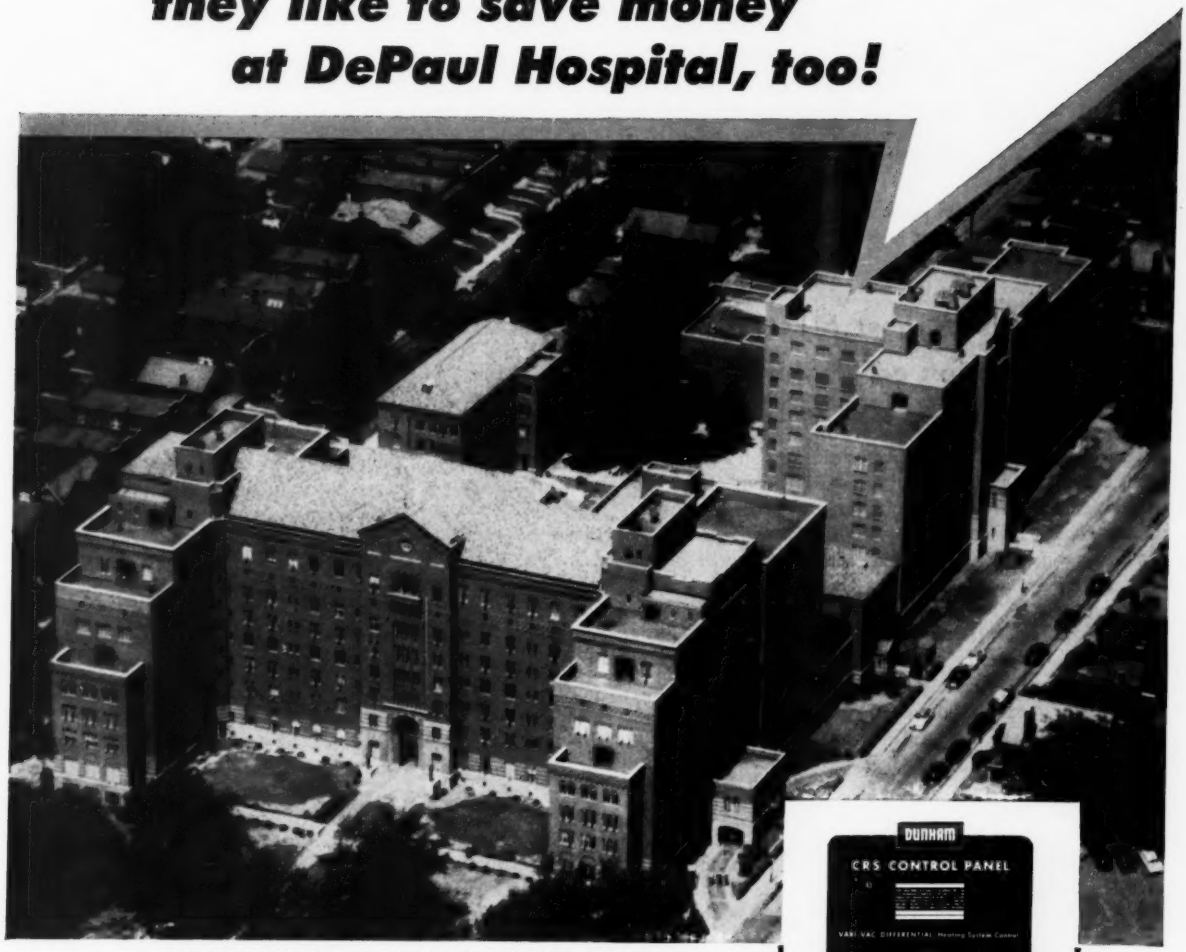
The average patient stay has become the yardstick by which hospitals measure their service to the community. The yearly drops of 0.2 or 0.3 a day are greeted with mutual congratulations by the administrative and medical staffs until almost everybody concerned with a patient is ready to discharge him from the hospital as soon as he is able to take a few unsteady steps.

This entire philosophy and system of goals will have to be eliminated in the care of the elderly patients. We must not forget that in this older age group there are a high number of incapacitating complications in even the simplest diseases and that preexisting physical conditions may well prevent an early postoperative discharge. The commonly complicated social situation in the homes of the aged is another factor which makes discharge planning extremely difficult. Social and medical planning and the full plexus of medical service, *i.e.* home care and follow-up clinics, will result in limiting to some extent the use of hospital beds to those who really need inpatient care. This will naturally result in a shorter stay, not so short as nine or 10 days, but that figure never will be reached if we assume our obligation to the aged or long-term ill.

Over the last decade Montefiore Hospital's average patient stay has been shortened from 174.5 days in 1941 to 79.5 days in 1952. Just how much the home care program had to do with this is problematical. On the neoplastic service from which most of the cases were drawn, the average stay in 1946 was about 107 days. In 1947, 1948 and 1949, the years home care became a factor, patient stay dropped to between 60 and 70 days. The average stay on home care was about 60 days.

A successful plan for the care of the aged in the average general hospital is a most complex and difficult one. It is a challenge worthy of our general hospitals and, if it is to be solved, every individual, from the president of the board of trustees to the potwasher, must be directly involved. A veritable revolution in orientation and planning will be necessary in many instances. Medical science has gradually been leading us to it through the back door by decreasing the number of acutely ill who need hospitalization. Let us now try a positive socio-medical approach to the real medical care problem of our day—the care of the aged and long-term ill.

they like to save money at DePaul Hospital, too!



DePaul Hospital, St. Louis, Mo. Architect: Maguola and Quick, St. Louis
Mech. Engr.: Harry F. Wilson, St. Louis • *Htg. Contr.:* Elliott and Barry Eng. Co., St. Louis

47,000 gallons of oil saved with DUNHAM VARI-VAC HEATING

DePaul Hospital, St. Louis, Mo., *saved over 47,000 gallons of fuel oil in a single heating season* . . . after changing over to Dunham Vari-Vac® Heating.

Hospital authorities state, "Even if we'd saved little or nothing on fuel, we'd still call Vari-Vac a good investment because of the greater comfort we enjoy."

Dunham patented temperature controls on high-vacuum steam mains can lower *your* fuel bills, too. That's because outside weather and inside heat losses *promptly* and *automatically* control steam consumption so that *you use less steam.* What's more, you can "zone heat" with Vari-Vac to meet varying conditions of building exposure and occupancy.

Full cost-cutting facts and figures on Dunham Vari-Vac Heating are yours if you just clip and mail the coupon.

DUNHAM **VARI-VAC HEATING**

RADIATION • UNIT HEATERS • PUMPS • SPECIALTIES
QUALITY FIRST FOR FIFTY YEARS
C. A. DUNHAM COMPANY • CHICAGO • TORONTO • LONDON

C. A. DUNHAM COMPANY
Dept. MH-1, 400 W. Madison St.,
Chicago 6, Illinois

Please send Vari-Vac literature

Name_____

Firm_____

Address_____

City_____ Zone____ State_____

NEWS DIGEST

A.S.T.A. Meeting Sets Attendance Record . . . McNamara Is President-Elect of Maryland-D.C.-Delaware Group . . . Missourians Discuss Integrated Medical Staff . . . Recommends Standards for Nursing Homes . . . Lists Consultant's Function

A.S.T.A. Has Largest Meeting, Hears Discussion on Hospital Buying

NEW YORK.—Registration at the semiannual meeting of the American Surgical Trade Association here last month reached 1050—largest by far in the association's history. This was the first association meeting at which technical exhibits were presented, according to Frank M. Rhatigan, secretary, and 75 manufacturers were represented in the exhibits. For companies unable to obtain space in the restricted exhibition area, the association set up "conference booths" in the meeting room, and an additional 18 companies were represented in these conference booths.

In one of the featured programs at the convention, Paul E. Widman, purchasing agent at the Cleveland Clinic in Cleveland, presented the point of view of the hospital purchasing agent toward the surgical supply dealer. In a challenging presentation, Mr. Widman expressed doubt that many surgical dealers could justify their existence on the basis of actual service rendered. "I realize that the local dealer can and does provide a distinct service to the community," Mr. Widman said. "That service is limited, however, and he should not try to step out of his jurisdiction and pretend that he can service most pieces of equipment that he sells."

Mr. Widman outlined the following points as the basis for purchasing policy at the Cleveland Clinic:

1. Develop standard specifications for supplies.
2. Supplies should be purchased and awards made on a competitive basis.
3. Competitors' prices should be disclosed only to recognized hospital authorities.
4. Business of the purchasing department should be conducted on a strictly ethical basis in accordance with the best economic practices, modern business methods being used.
5. Determine minimum and maximum inventories required to meet the needs of the institution.
6. Use of the hospital's name in endorsement of commercial products should be prohibited.
7. Purchasing for personal use of employes is not a legitimate departmental activity and should not be added to the burden of purchasing personnel.
8. The statement of credit standing and cash position of the hospital should be clearly understood.
9. Other things being equal, purchase from local sources.

Speaking on behalf of the dealer, Benjamin F. Gordon, president of the Harold Supply Corporation, emphasized the many services dealers can perform for doctors and hospitals. Without the dealer, Mr. Gordon pointed out, the manufacturer could not provide equivalent service except at greatly increased expense.

Speaking on the same program with

(Continued on Page 182)

Nebraska Meeting Draws Registration of 612

LINCOLN, NEB.—Floyd Grady, administrator, Morrill County Veterans Memorial Hospital, Bridgeport, became president of the Nebraska Hospital Association in November at the association's annual convention here, and Herbert A. Anderson, administrator of Lincoln General Hospital, Lincoln, was named president-elect.

The association's new officers also include: vice president, Jack Hurley, business manager, St. Francis Hospital, Grand Island, and secretary, Duane Johnson, administrator, University of Nebraska Hospital, Omaha. Sister Mary Kevin, R.S.M., administrator of St. Catherine's Hospital, Omaha, was reelected treasurer.

With 11 allied organizations meeting in conjunction with the state association convention, registration at the two-day sessions totaled 612.

Ruth Sleeper, president of the National League for Nursing, and the Rev. John J. Flanagan, S.J., executive director of the Catholic Hospital Association of the United States and Canada, were among the convention's featured speakers.

Officers of the Nebraska association (left to right): Herbert A. Anderson, president-elect; Duane Johnson, secretary; Sister Mary Kevin, R.S.M., treasurer; Jack Hurley, vice president, and Floyd E. Grady, incoming president.

NEWS...

Hoyt and McNamara Head Three-State Group

BALTIMORE.—Fred A McNamara, chief of the hospital section, U.S. Bureau of the Budget, Washington, D.C., was named president-elect of the Maryland-District of Columbia-Delaware Hospital Association at its meeting here in November.

Robert S. Hoyt, administrator of Lutheran Hospital of Maryland, Inc., Baltimore, became president of the meeting succeeding Brady J. Dayton, administrator, Peninsula General Hospital, Salisbury, Md.

The association also elected Dr. Russell A. Nelson, director, Johns Hopkins Hospital, Baltimore, first vice president; Grace L. Little, superintendent, Memorial Hospital, Wilmington, Del., was reelected second vice president, and Victor F. Ludewig, superintendent, George Washington University Hospital, Washington, D.C., was elected third vice president. The secretary is W. C. Anderson, director, Kent General Hospital, Dover, Del., and the new treasurer, C. Parker Sheppard, controller, Lutheran Hospital of Maryland, Inc., Baltimore.

Trustees of the association voted approval for the undertaking of steps designed to improve training of nurse's aides and orderlies within the nation's hospitals. The project is a pilot study for the proposed nurse's aide project, sponsored jointly by the American Hospital Association, the National League for Nursing, and the U.S. Public Health Service.

C. Rufus Rorem, executive director of the Hospital Council of Philadelphia, addressed the opening session. "The hospital patient gets a bargain for his dollar," he said, "but this is cold comfort to the man who cannot pay his bill." He maintained that the solution lies in hospitalization insurance plans. "When the specter of hospital bills no longer haunts the families of our nation, the people will rise to bless the institutions in which their lives are saved and their health is restored."

Speaking at the luncheon of women's auxiliaries, Mrs. Abraham Pinanski of Boston, past chairman of the A.H.A. committee on women's auxiliaries, urged auxiliaries to be willing "to accept job assignments that seem neither responsible nor dramatic; we must realize that any job assignment is vital and important if, by our doing it, we relieve trained personnel for the procedures for which we lack the training."

At the Maryland meeting, Ritz Heerman, center, congratulates Fred A. McNamara, right, president-elect. At left is Robert A. Hoyt, the incoming president.

Other speakers at the two-day convention included: Ritz E. Heerman, president of the A.H.A., Dr. William K. Diehl, assistant professor of gynecology at the University of Maryland, and Richard K. Griffith, director of the Delaware Hospital, Wilmington. Leo G. Schmelzer, administrator of Garfield Memorial Hospital, Washington D.C., presided.

Retiring President Dayton and Mr. Schmelzer were elected to the board of trustees through 1956. A.H.A. delegates reelected were Mr. Schmelzer, for the District of Columbia; Richard Griffith, for Delaware, and J. Douglas Colman, vice president of Johns Hopkins University and Hospital, for Maryland.

Section meetings held during the convention included: nurse anesthetists, medical technologists, purchasing, medical record librarians, women's auxiliaries, dietitians, accountants, pharmacists, medical social workers and executive housekeepers.

Negro-White Medical Staff Discussed at Missouri

ST. LOUIS.—The 1953 convention of the Missouri Hospital Association held here November 19 and 20 broke all previous attendance records with a new high of 503 registrants.

Horace L. Burgin, administrator of Burge Hospital, Springfield, was named president-elect. Herbert S. Wright, administrator, Southeast Missouri Hospital, Cape Girardeau, became president during the meeting.

Other officers are: vice president, Dr. B. I. Burns, hospital commissioner, Kansas City; second vice president, Brother Bede Guyon, administrator, Alexian Brothers Hospital, St. Louis; treasurer, the Rev. E. C. Hofius, administrator, Lutheran Hospital, St. Louis. New trustees are Harry E. Panhorst, associate director, Washington University Clinics, St. Louis, and G. O. Lindgren, administrator, Trinity Lutheran Hospital, Kansas City.

The record delegation attending the two-day sessions heard Albert M. Spradling Jr., chairman of the state senate committee on public health and welfare, speak at the association's luncheon meeting. Later that afternoon (November 19) the operation of a general hospital with a mixed staff was discussed by James H. Moss, administrator of Audrain Hospital, Mexico, and Ted O. Lloyd, administrator of Phelps County Memorial Hospital, Rolla. Following their presentations, Dr. Charles LeTourneau, secretary of the A.H.A.'s council on professional practice, explained the association's position on Negro-white medical staffs.

Missouri association officers, left to right: Dr. David Littauer, retiring president, Dr. B. I. Burns, first vice president; Herbert S. Wright, president; Horace L. Burgin, president-elect; Rev. E. C. Hofius, treasurer. Harry E. Panhorst (rear) and G. O. Lindgren, far right, were elected trustees.

Abbott's COMPLETE I.V. AND BLOOD TRANSFUSING Equipment

Sterile, pyrogen-free and ready-to-use

COLLECTING AND PRESERVING BLOOD

For Vacuum Collection:

ABBO-VAC®—A-C-D Solution, U.S.P. (N.I.H. Formula B), in Universal bottles, 500- and 250-cc. sizes. Blood is drawn directly into container by vacuum. Sterile, disposable Blood Donor Set also available.

For Gravity Collection:

NON-VAC®—A-C-D Solution, U.S.P. (N.I.H. Formula B), in Universal bottles, 500- and 250-cc. sizes. Blood is drawn directly into container (closed technique) by gravity. Donopak® 24 and 48, with or without attached, sterile, disposable needles also available.

Abbott A-C-D Blood Container—A-C-D Solution, U.S.P. (N.I.H. Formula B), in the familiar Abbo-Liter® intravenous bottles, 500- and 250-cc. sizes. Blood is drawn (closed technique) directly into container by gravity. Available with Sodium Citrate 3% Solution in 500-cc. size. Donopak 24 and 48, with or without disposable needles also available.

For Storing Plasma:

Evacuated Empty Plasma Containers—Sterile evacuated 500- and 250-cc. Universal bottles for storing, transporting and administering plasma or serum.

ADMINISTERING BLOOD and/or SOLUTIONS

Blood Recipient Set—Sterile, disposable, ready-to-use plug-in set for administering blood from any Universal bottle or Abbo-Liter type bottle. Has flexible plastic filter chamber.

VENOPAK®—Abbott's sterile, disposable venoclysis unit for the administration of all intravenous solutions. Converts readily to a blood recipient set with a special, disposable blood filter. For use exclusively with Abbo-Liter® containers.

(Series Hookup)

Secondary Recipient Set—A unique, disposable unit with a built-in, flexible drip chamber and filter. Designed to plug into any Universal blood bottle and to connect with Abbott's VENOPAK dispensing cap. Allows changeover from saline to blood in a matter of moments, without removing needle from vein.

Secondary VENOPAK—Disposable unit designed for the continuous administration of fluids in the series hookup with VENOPAK.

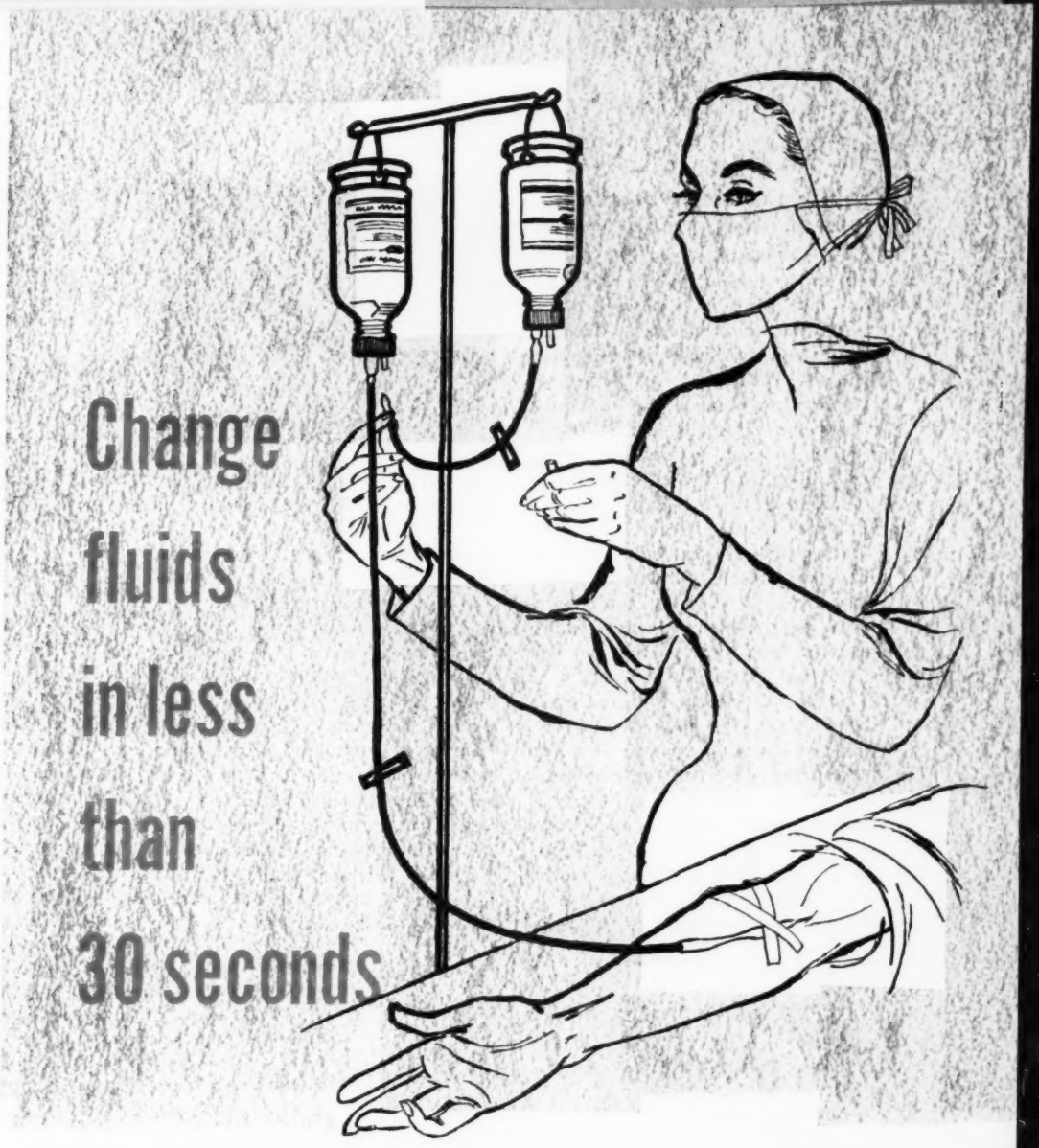
ADMINISTERING FLUIDS SUBCUTANEOUSLY

SUB-Q-PAK®—A completely disposable, preassembled hypodermoclysis unit with plastic Y tube for administration of fluids subcutaneously.

ADMINISTERING PENTOTHAL® SODIUM

VENOTUBE®—Length of plastic tubing with attached male and female Luer adapters and pinch clamp. Allows anesthesiologist to keep syringe off the patient's arm. Pinch clamp offers additional factor of safety.

*Trade mark



with Venopak® series hookup

WHEN seconds count, you can change fluid therapy in less than 30 seconds with Abbott's easy-to-use VENOPAK® in series hookup. There's no time-consuming dismantling and reassembling of equipment, no second venipuncture to disturb the patient. Danger of air embolism is minimized. The operator simply suspends the second fluid container in position and inserts the needle adapter of the Secondary VENOPAK into the air vent of the primary container. Like all others in the Abbott I. V. line, this unit is sterile, pyrogen-free and ready to use. Ask your Abbott representative for a demonstration. Or write to, Abbott Laboratories, North Chicago, Illinois. Abbott

INVESTIGATE THE COMPLETE I. V. LINE

NEWS...

Problem Solving Technic Used at Illinois Convention

SPRINGFIELD, ILL.—At the conclusion of its annual meeting held here last month, the Illinois Hospital Association elected Wendell H. Carlson, administrator of Englewood Hospital, Chicago, president for 1955. Dr. George H. VanDusen, administrator of Christian Welfare Hospital, East St. Louis, retiring president of the association, was succeeded by Russell H. Duncan, administrator of the Carle Memorial Hospital, Urbana.

Nearly 200 hospital administrators and health leaders attended the meetings of the 31st annual convention, which this year stressed open discussion and grass-roots problem solving rather than formal presentations.

Addressing delegates at the banquet, Gov. William G. Stratton discussed the health program of the state administration. He said he favored a continuing program of state aid to meet the need for modern hospitals and clinics in sparsely populated areas of Illinois. In addition to group conferences, a symposium of trustee-doctor-administrator relations was held. Participating in the discussion were: Stanton K. Smith, chairman of the board of Rockford Memorial Hospital, Rockford; Dr. R. J. Hyslop, president of medical staff of Deaconess Hospital, Freeport; Joseph G. Norby, executive secretary of United Hospitals Fund of Milwaukee County, Milwaukee, and Dr. John Hinman, assistant to the director of the Joint Commission on Accreditation of Hospitals, Chicago. Lester C. Mortrud, administrator, Ingalls Memorial Hospital, Harvey, was discussion leader.

Dr. George H. VanDusen (left) turns over the gavel of the Illinois Hospital Association to Russell H. Duncan.

Eva H. Erickson, administrator of Galesburg Cottage Hospital, Galesburg, Ill., conducted an open forum on nursing. William S. McNary was guest speaker at the association luncheon.

Officers elected by the association are: first vice president, the Rev. John Weishar, director of hospitals, archdiocese of Peoria; second vice president, Leonard W. Hamblin, administrator of Deaconess Hospital, Freeport, and secretary-treasurer, Veronica Miller, superintendent of Henrotin Hospital, Chicago. New trustees are: Ray E. Brown, superintendent of University of Chicago Clinics; Dr. Stephen Manheimer, director of Mount Sinai Hospital, Chicago; Lester C. Mortrud, administrator of Ingalls Memorial Hospital, Harvey, and Orville Peterson, administrator of Copley Memorial Hospital, Aurora.

Virginia Group Names Beale President-Elect

ROANOKE, VA.—The Virginia Hospital Association named Walter L. Beale, administrator of Norfolk General Hospital, Norfolk, president-elect at its annual meeting held here late in November.

Officers of the association who take over their duties on January 1 are: president, Homer E. Alberti, administrator, Winchester Memorial Hospital, Winchester, Va.; secretary, Raymond E. Hogan, administrator, Giles Memorial Hospital, Pearisburg; treasurer, William H. Hoobler, administrator, Memorial and Crippled Children's Hospital, Roanoke.

Trustees are: Charles P. Cardwell Jr., director, Hospital Division, Medical College of Virginia, Richmond, and Roy C. Brown, administrator, Johnston Memorial Hospital, Abingdon. Mr. Cardwell was also named the association's delegate to the A.H.A. convention.

Norwalk Hospital Adds Community Pavilion

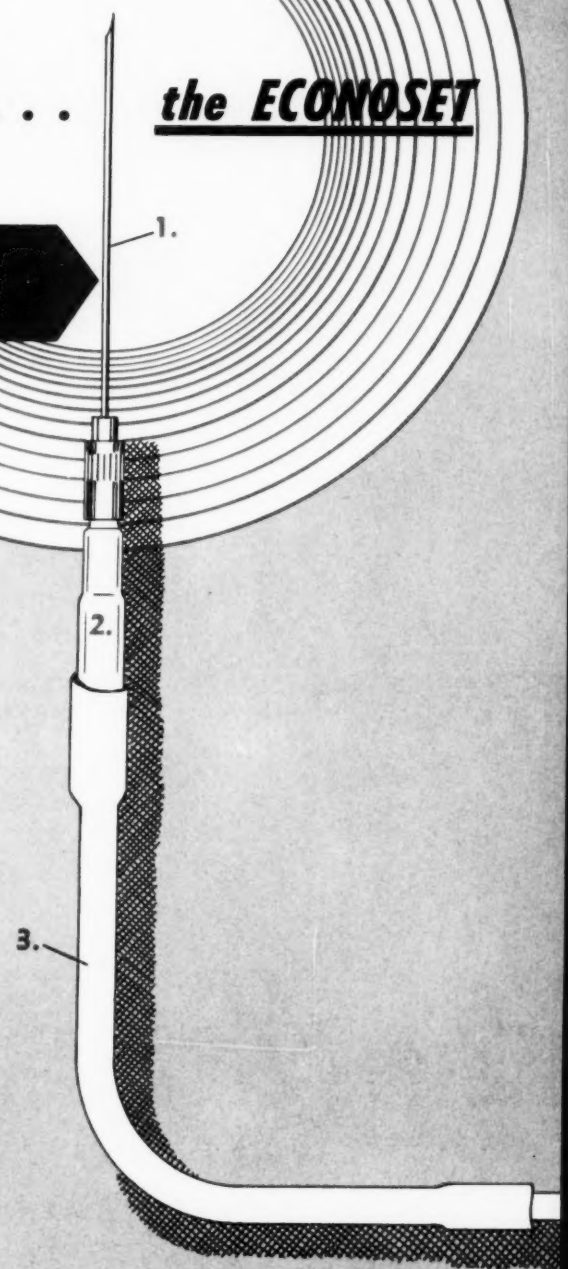
NORWALK, CONN.—Norwalk General Hospital, with the opening of the new $1,795,000 wing late in November, now can accommodate 350 patients. The new wing adds 60 beds to the hospital's capacity.

The addition is called Community Pavilion, inasmuch as the entire cost of the construction was pledged by residents of Norwalk and the surrounding communities the hospital serves—Darien, New Canaan, Ridgefield, Wilton, Weston and Westport.

the 1st Time, a complete

intravenous administration set . . . . *the ECONOSET*

with INTEGRAL NEEDLE



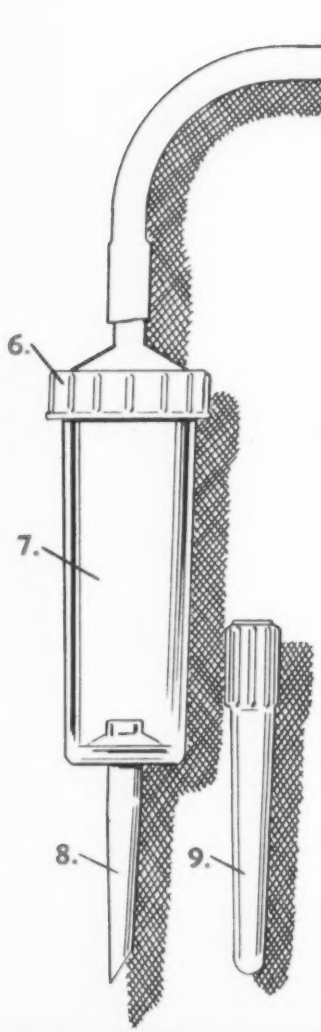
Zoller Chemical Corporation, a subsidiary of R. W. Ogle and Company, world's largest manufacturer of plastic disposable syringes and dispensers, introduces the ECONOSET. This superior intravenous administration unit lives up to its name! It is priced right and is the only complete and disposable IV administration set on the market today because it INCLUDES a detachable luer taper needle. ECONOSET comes to the hospital ready for immediate use . . . sterile, pyrogen free and non-toxic.

ECONOSET also features a 4-inch latex tubing on both ends of the unit making it the only IV adminisration equipment suitable for use in patient's room AND in surgery for supplemental medication.

Hundreds of leading hospitals in all parts of the country are NOW using ECONOSETS. For patient protection, positive action and UNBEATABLE ECONOMY, the best IV set is the ECONOSET.

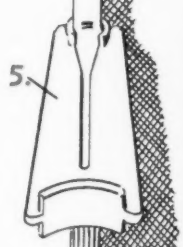
HOSPITAL PRICE SCHEDULE
10M or more per year .45c including needle
3M-10M per year .475 including needle
Less than 3M per year .50 including needle

ZOLLER **CHEMICAL CORPORATION**

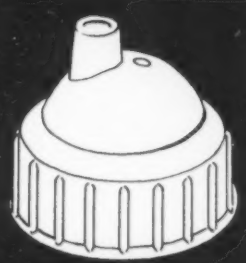


9 FEATURES

1. A new, sharp, clean, intravenous needle—sterile, burr-free, detachable.
2. Visible flow adaptor.
3. ZOLEX—a superior intravenous self-sealing latex tubing for administration of supplemental administration during venocylsis.
4. ZOLON—a new crystal-clear plastic tubing—non-creasing, non-toxic
5. Flow meter clamp permits easy rate selection and positive shut-off when desired.
   NOTE: Re-useable as catheter clamp.
6. Flexible plastic funnel adaptor increases reservoir area of lower portion of drip meter barrel.
7. Clear-view leakproof plastic drip meter barrel with special conical drip indicator provides positive rate selection at any angle.
8. Integral bevelled cannula provides an abrasion-free non-coring entry through any rubber stopper.
9. A sterile seal plastic cap on both ends of set maintains sterility.



ZOLLER SCREW CAP ADAPTOR



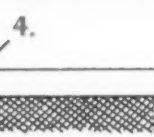
This adaptor allows both the Sterilset and Econoset to be used with solutions having standard screw cap closures. Available at slight extra charge.

Also available:

The Sterilset — a companion set—WITHOUT NEEDLE. At slightly lower prices incorporating all the exclusive features of the Econoset.

HOSPITAL PRICE SCHEDULE

10,000 or more per year . 40c
3,000 to 10,000 per year . 425c
Less than 3,000 per year . 45c



SOLD THRU LEADING SURGICAL SUPPLY DEALERS • FREE SAMPLES SUPPLIED UPON REQUEST

ZOLLER CHEMICAL CORPORATION

SUBSIDIARY OF R. W. OGLE & COMPANY

3440 WILSHIRE BOULEVARD • LOS ANGELES, CALIFORNIA

NEWS...

Women to Head Oklahoma Association for Two Years

TULSA, OKLA.—Sister Mary Agnes, superintendent, St. Anthony's Hospital, Oklahoma City, was chosen president-elect, and Margaret Lamb, administrator of Norman Municipal Hospital, Norman, was installed as president of the Oklahoma State Hospital Association held here November 12 and 13.

Other officers of the association are: vice president, Art McElmurry, business manager of University Hospital, Oklahoma City; secretary, Tom Wicker, administrator, Southwestern Clinic Hospital, Lawton, and treasurer, Jack Shrode, administrator, Wesley Hospital, Oklahoma City.

Elected to the board of trustees were: Robert Trimble, administrator, LeFlore County Memorial Hospital, Poteau; Bryce Twitty, administrator, Hillcrest Memorial Hospital, Tulsa; R. L. Loy, business manager, Mercy Hospital Oklahoma City General, Oklahoma City, and Joe Baker, administrator of Enid General Hospital, Enid.

As a permanent part of its program, the association voted for a uniform accounting and record keeping project; it also acted to retain the services of Vol G. Edmondson on a full-time basis to assist in the project.

The program, which recommended a cure for each hospital malady it dealt with, scheduled something for everyone of the 455 delegates attending the convention.

Dr. John Hinman, assistant director of the Joint Commission on Accreditation, opened the afternoon session by prescribing accreditation as an antidote to his topic "Generalized Infection" of hospitals.

This talk was followed by a panel discussion participated in by: Dr. Curtiss Lohr, administrator of St. Louis County Hospital, St. Louis; Newton R. Graham, chairman, board of trustees, Hillcrest Memorial Hospital, Tulsa; Dr. W. Pat Fite, Muskogee; Naomi Alford, medical record librarian, University Hospital, Oklahoma City, and Ruby Beauclair, director of nurses, Valley View Hospital, Ada.

Employe and patient hypertension had been diagnosed and prescribed for by Sister M. Rosina, O.S.F., St. Anthony's Hospital, Oklahoma City, and C. J. Foley of the A.H.A.

General sessions also featured talks on records, rates, collections, safety and nursing.

Among the groups that convened on November 12 were the medical record librarians, the housekeepers, and the dietitians.

Joseph Coppa New Head of Arizona Association

PHOENIX, ARIZ.—The Arizona Hospital Association at its annual convention here late in November named its new officers for the year. Joseph Coppa, administrator of Mohave General Hospital, Kingman, was elected president.

Other officers are: vice president, Dr. Francis Bean, administrator of Pima County General Hospital, Tucson; secretary-treasurer, Guy M. Hanner, administrator, Good Samaritan Hospital, Phoenix. M. G. Wolfers, administrator of Tucson Medical Center, Tucson, and F. H. Wachter, administrator, Community Hospital Association, Wickenburg, were named trustees for a three-year term.

Gold Seal Nairn Inlaid Linoleum

Consider these virtues that make Gold Seal Inlaid Linoleum more economical in the long run than almost any other floor covering. It's virtually seamless-smooth . . . with no dirt-catching cracks. It's tough—so tough it reduces replacement problems. Installations giving service to heavy traffic for over 30 years are still in business. And its remarkable blend of resiliency and resistance stands up under heavy furniture . . . gives maximum comfort under foot. "Veltone" in 18 patterns. "Jaspe" in 6 patterns. "Plain" and "Battleship" in 10 solid colors. ⅛" gauge with burlap back. 6′ wide by the yard. *Our elephant's ears are Gold Seal "Jaspe"; his tusks, "Battleship"; his head, "Veltone"; his hat, "Plain" Linoleum.*

GOLD SEAL ® **Floors and Walls**

CONGOLEUM-NAIRN INC. Kearny, N. J. © 1954

NEWS...

V.A. Dismisses 134 for Security Reasons

WASHINGTON, D.C.—For security reasons, a total of 134 employes have been separated from the Veterans Administration since last May 27.

These separations, V.A. said, are apart from reductions in force in the agency for economy reasons.

Of the 134 employes processed under the Employes Security Program, Executive Order 10450, 108 had their services terminated and 26 resigned while under investigation.

The V.A. points out that while security investigations are conducted under authority of the executive order, all administrative actions are taken in accordance with civil service procedures. Security regulations provide that the authorities contained in the executive order will supplement and not replace normal civil service procedures where the latter are adequate for the purpose.

In keeping with the announced policy of the Administration, V.A. will not normally make public the names or case histories of persons who have been separated from federal service.

Heads Social Workers

WASHINGTON, D.C.—At the November meeting of the executive committee, the American Association of Medical Social Workers here elected Pauline Ryman, director of social service at Strong Memorial Hospital, Rochester, N.Y., president.

First vice president is Doris Siegel, director of social service at Mount Sinai Hospital, New York City. Mary M. Lewis, director of social service, Washington University Clinics and Allied Hospitals, St. Louis, is second vice president.

Moving Moves Swiftly

FORT WAYNE, IND.—It took just six hours to move patients and equipment from Methodist Hospital near downtown Fort Wayne to the new $4,500,000 hospital on the northeast edge of the city. Police kept the 2½ mile route clear during the transfer. The new hospital has been built on an 18 acre wooded tract. Don Carner is administrator of the hospital.

DOGS, CATS DIDN'T GET THIS $2½ MILLION

BROOKLYN, N.Y.—Back in 1937 a plainly dressed woman dropped into the Methodist Hospital of Brooklyn to look around. It seems that she and her husband couldn't agree on what to do with their money after they died.

Dr. Chester Marshall, then director of the hospital, talked to Mrs. Stanley H. Miner, for that was the woman's name, and found out that she was very interested in pets and would like the money to go to a dog and cat hospital. Her husband wasn't so interested in pets and wasn't sure that he agreed with her.

Dr. Marshall was not convinced that the Miners had any money at all to leave. But he told her that the hospital needed renovating, a job that would cost $25,000. Mrs. Miner did not seem staggered at this sum.

Growing bolder, Dr. Marshall pointed out the window at the hospital's ancient ward surgical pavilion and said it should be replaced at a cost of a million dollars.

Mrs. Miner seemed interested and left, saying the hospital might hear from her again.

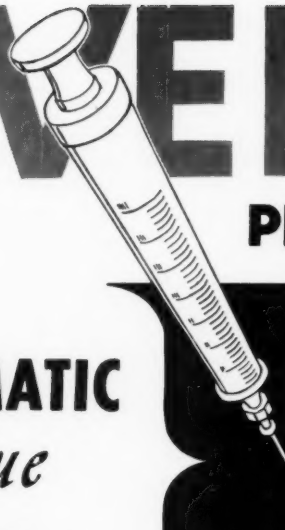
And it did. Late in November 1953 the hospital announced that it had received a bequest of $2,500,000 from the estate of Mr. and Mrs. Stanley H. Miner. The money will be spent not on a surgical pavilion but to replace the 70 year old administration building, which also houses 100 patients.

Blue Cross Plans Total 45,505,618 Members

CHICAGO.—For the first nine months of 1953, Blue Cross has reported an enrollment increase in its 85 plans of 1,960,702, thus surpassing both the 1951 and 1952 experiences. As of Sept. 30, 1953, the Plans show a total membership of 45,505,618, the Blue Cross Commission announced here last month.

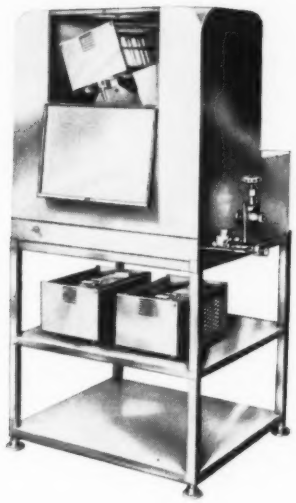
The per cent of the nation's population enrolled in Blue Cross rose to 28.30, the commission stated, adding that its District IV led all districts with 50.33 per cent of its population enrolled. The district includes Plans in Wilmington, Del., and Allentown, Harrisburg, Philadelphia, Pittsburgh and Wilkes-Barre, Pa.

SAVED . . PRECIOUS LABOR



KLEEN-O-MATIC *technique*

CUTS MAN-HOUR COSTS 90% on time-consuming SYRINGE and NEEDLE CLEANSING



KLEEN-O-MATIC NEEDLE WASHER and RINSER

safety and savings!

SYRINGE and GENERAL GLASSWARE WASHER

- ***Fast***
- ***Simple***
- ***Economical***
- ***Adaptable***

Ferris-like wheel holding four removable baskets rotates syringes, or other glassware, through hot detergent solution (temperature boosted by 2 immersion heaters) for remarkable ease of washing. Important safety factor in that personnel never touches contaminated glassware until processing is completed. When the syringes have been thoroughly washed and rinsed, syringe holder is removed from baskets for simple, predetermined matching of barrels and plungers before autoclaving. Normal washload of 4 full baskets requires 30-minute cycle for one wash, two rinses. Stainless baskets each hold 64 2cc syringes; 45 5cc syringes; 30 10cc syringes. Other baskets accommodate 20, 30, 50 and 100 cc syringes . . . as well as being equally adaptable to all Central Supply's small glassware . . . and even formula bottles.

Washer in bench model, or available on steel platform, optional at extra cost.

Installation requirements: hot water, drain, and 220 volt, 4500 watt, 60 cycle, single phase electrical connections. Steam heat model available.

Send for illustrated folders

Needle washer-rinser will process 700–1,000 needles an hour . . . compare this with your present needle washing requirements! Needles pre-soaked from floors in specially designed manifolds which are inserted, as is, into washer for ½ minute, then to rinser for ½ minute. Clean needles then emptied onto inspection tray before autoclaving. Drying cycle has been purposely omitted as unnecessary. Thus, the compressed air fixture and an extra bothersome step are avoided.

Hot detergent solution is forced down outside of needle shaft, then up through lumen and swirled through hub, eliminating vibration. Effects very superior cleansing with no dulling of needle points, as experienced with reverse flow cleansers.

All-important is the fact that your personnel will never come in contact with contaminated needles until processing has been completed.

MACALASTER BICKNELL
Parenteral Corporation
CAMBRIDGE 39, MASSACHUSETTS

Branch offices: Atlanta, Ga.; Columbus, Ohio; Milleville, N. J.; New Haven, Conn.; New York, N. Y.; Shreveport, La.; Syracuse, N. Y.; Washington, D. C.

ORIGINAL DISTRIBUTORS OF THE FENWAL SYSTEM

NEWS...

Physician Recommends Standardization of Nursing Homes

CHICAGO.—In an article published in the December 19 issue of the *Journal of the American Medical Association*, Dr. Thomas P. Murdock of Meriden, Conn., a member of the board of trustees of the A.M.A., expressed himself as believing the time has come for standardization and increased bed capacity of nursing homes.

"The overloading and overburdening of the general hospitals, the increased cost of hospitalization, the increase in life expectancy, the large numbers of persons covered by prepaid hospital and medical plans, and the undoubted increase in the number of persons suffering from long-duration illness all indicate that from this time on the nursing homes will take their rightful places in the sun," Dr. Murdock wrote.

Pointing out that the 14,000 nursing homes of the country differ in their degrees of acceptability, Dr. Murdock said standardization is a necessity, but must be done cautiously and carefully on the basis of pattern direction and by a voluntary approach.

Speaking of medical care in nursing homes, Dr. Murdock had several recommendations to make: "Where possible, these homes can be annexed to the general hospital. If this is not possible, an affiliation with a general hospital may be accomplished. It is of benefit to the general hospitals to know that a suitable affiliation exists where their patients with long-duration illness will be adequately cared for.

"I would urge that, wherever possible, the medical care be provided on a voluntary basis. In the larger homes, by which I mean those of 100 to 200 beds, I would recommend that a regular staff be appointed. If the home is attached to a general hospital, the staff can be provided by the general hospital. If not, the county or city medical society will aid in the selection. In smaller hospitals, the same procedure will apply, or the patient may have his own physician. Wherever possible, the free choice of physicians should apply."

Dr. Murdock suggested that all patients in nursing homes should have preadmission chest x-rays, that their mode of living should not be changed so that ultrascientific procedure supplants comfort, and that a physical examination be given at least twice yearly.

"We must always bear in mind that the nursing home is and should be operated for the kindly, gentle care of these old persons who find themselves in the late period of their lives without any place to go, who are entitled to good care, and who do not need overly scientific study," he stressed.

Methodists Add Two Rochester Hospitals

CHICAGO.—Effective January 1, two Rochester, Minn., hospitals will become part of the Methodist organization. Formerly known as the Colonial and Worrall hospitals, they now become the Rochester Methodist Hospital, according to an announcement last month by the Board of Hospitals and Homes of the Methodist Church here.

Grand opening celebration has been scheduled for January 3.

NEWS...

A.P.A. Committee to Certify M.D.'s as Heads of Mental Hospitals

WASHINGTON, D.C.—To ensure that the chief executives of mental hospitals shall not only be physicians adequately trained in psychiatry, but that they shall also be skilled in business and personnel management, community relations, budget control, procurement and other essential administrative technics, the American Psychiatric Association has set up a committee to certify physicians as "qualified mental hospital administrators," Dr. Kenneth E. Appel of Philadelphia, association president, announced last month.

The certification system is just one of several steps the association has taken in recent years to raise standards of treatment and care for the mentally ill, Dr. Appel said.

Chief executives of mental hospitals must be physicians specializing in psychiatry, the association maintains. It regards proposals to separate "administrative" from "medical" responsibility in the hospital with corollary suggestions that doctors should confine themselves to medical matters only as unsound, and believes that all mental hospital operations bear a direct relation to the therapeutic progress of a patient, and accordingly that only a physician may assume total responsibility for them.

Dr. Francis J. Braceland of Hartford, Conn., heads the new committee on certification of mental hospital administrators of the A.P.A. Other members are: Drs. William B. Terhune, New Canaan, Conn.; George W. Jackson, Topeka, Kan.; Walter H. Baer, Peoria, Ill.; Granville L. Jones, Williamsburg, Va.; Frank F. Tallman, Los Angeles; Arthur M. Gee, Essondale, B.C., Canada; Harold W. Sterling, North Little Rock, Ark.; Jack R. Ewalt, Boston, and G. Wilse Robinson, Kansas City, Mo. Consultants to the committee are: Drs. Winfred Overholser, Washington, D.C.; Mesrop A. Tarumianz, Farnhurst, Del., and Hayden H. Donahue, Oklahoma City, Okla. Dr. C. N. Baganz, manager, Veterans Administration Hospital, Lyons, N. J., is secretary of the committee.

In a statement about political interference with the administration of public mental hospitals in various states, Dr. Appel pointed out that these states seriously threaten the gains made in recent years in the care of the mentally ill.

"The American Psychiatric Association urges political leaders everywhere to take stock of the incalculable damage they do when they sacrifice the professional staffs of our mental hospitals to a fleeting political advantage," he said.

Consultants Convene at New Clinical Center

BETHESDA, MD.—The American Association of Hospital Consultants met here in December to study the extensive facilities of the new Clinical Center of the National Institutes of Health of the U.S. Public Health Service.

The program featured talks by Richard Bolt, director of the acoustic laboratory, Massachusetts Institute of Technology, who spoke on "Acoustics in Hospitals," and Robert Cutler of the New York office of Skidmore, Owings and Merrill, architects, whose topic was "Modern Hospital Architecture." Also included in the program was a symposium on radioisotopes, and a general tour of the laboratories and special facilities of the Clinical Center.

Dr. Harvey Agnew, partner of the firm of Neergaard, Agnew, Craig and Westermann, Toronto, Ont., succeeded Dr. E. M. Bluestone, consultant to Montefiore Hospital, New York City, as president. Other officers named were: vice president, Dr. Jack Masur, assistant surgeon general, Washington, D.C., and secretary-treasurer, Jacque Norman, hospital consultant of Greenville, S.C. Dr. Bluestone and Dr. Charles Wilinsky of Boston were named executive members.

Dr. Masur and Dr. Vane M. Hoge, both assistant surgeon generals of the Public Health Service, were the meeting's hosts.

Opens Psychiatric Unit

CHICAGO.—Passavant Memorial Hospital here opened a unit for psychiatric care last month. Providing 14 beds with special facilities for psychiatric treatment and occupational therapy, the unit will serve temporarily until the hospital's plans for a full psychiatric floor are completed, hospital officials said.

How do you buy paper containers?

All-Sealright paper service. The new heat 'n serve plastic-coated container for moist food serving, the single service Kone Bottle for liquids, the container cover..a perfect cantaloupe holder.

There's no sense buying ordinary paper containers when you can pick Sealrights. Made under famous Sealright Sanitary Service laboratory conditions, more and more hospitals are turning to Sealright as their *complete* paper container supply source. And, they're finding out that new Sealright Sanitary packaging developments are increasing hospital efficiency and speeding up service.

Take the plastic-coated Sealright Moist Food Nestyle container. It's the first container to eliminate paper taste and to provide a pleasant, true-flavor drinking surface. The new container will even take oven baking of individual portions of chicken or meat pies.

Always Attractive. Gelatine desserts are prepared in plastic-coated new type moist food Sealright Nestyle containers.

ALL SIZES of Sealrights for operating room and laboratory use. Specially suitable because inside surface is plastic lined for non-absorbency.

Sealright

We use SEALRIGHT SANITARY SERVICE for Your Protection

PAPER CONTAINERS

Oswego Falls Corp. — Sealright Co., Inc., Fulton, N. Y., Kansas City, Kansas — Sealright Pacific, Ltd., Los Angeles, California — Canadian Sealright Co., Ltd., Peterborough, Ontario, Canada.

SEALRIGHT CO., INC. MH541
Fulton, N. Y.

Please send me some sample Sealright containers so I can see for myself the job they can do.

Name ..... **Title** .....

Company Name .....

Address .....

City ..... **State** .....

NEWS...

A.M.A. Makes New Doctor-Hospital Statement

(*Continued From Page 62*)

necessarily unethical, the action of the house of delegates in approving the Judicial Council's report appeared to some to be in conflict with the earlier action asserting that the statement opposing sale of a physician's services for a fee had not been replaced or repealed.

If it was thus hard to determine the intent of the house with respect to hospital-physician relations generally, there was no mistaking its intent with respect to the Swift & Company contract: The A.M.A. doesn't want any part of an insurance contract which classifies radiology, pathology and anesthesiology as hospital services. The specific resolution on this subject was introduced by Dr. Percy E. Hopkins of Chicago, chairman of the committee on prepayment medical and hospital service of the A.M.A.'s Council on Medical Service. Referring to the contract between Health Service, Inc., and employes of the meat packing industry and their dependents, the resolution stated that "the issuance of these contracts is evidence of continued disregard of the principles as set forth by the house of delegates of the American Medical Association, which principles define pathology, radiology, anesthesiology and physiatry as medical services."

Making note of the fact that Health Service, Inc., the Blue Cross insurance company, is affiliated in an underwriting agreement with Medical Indemnity of America, Inc., its Blue Shield counterpart, the resolution went on to condemn "all insurance contracts which classify any medical service as a hospital service," and to "reaffirm all past actions of the house of delegates relating to the subject."

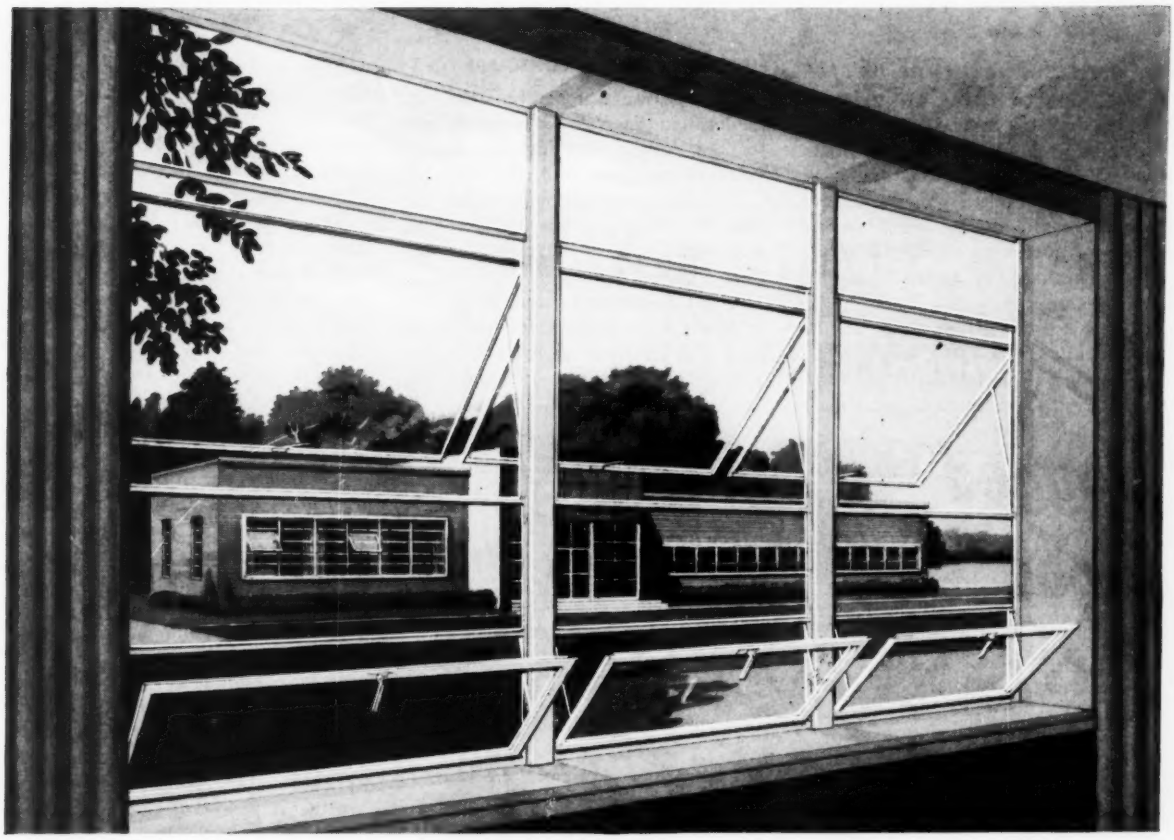
Members of the Council on Medical Service, it developed, were infuriated by a provision of the Swift & Company contract with Health Service, Inc., under which laboratory examinations, anesthetics, and x-ray examinations were named among the special hospital services to be included as hospital benefits "when rendered as a regular hospital service and performed by a hospital employe." At the same time, the Swift contract specifically excluded "charges for pathology, radiology or anesthesiology" from its list of medical benefit provisions.

As explained by a Blue Cross official, these provisions are identical with the benefits included in a contract made with the steel industry two years ago and were specifically demanded by the packinghouse workers. "The fact is that if we had written the contract differently these workers would be left without any benefit for these services, for all practical purposes," the Blue Cross official explained, "because in the majority of cases the hospital still bills and collects for these services."

For Blue Cross and Blue Shield, Health Service, Inc., and Medical Indemnity of America, Inc., have been the means of equalizing benefits among plans and writing contracts that are competitive with commercial insurance contracts on a nationwide basis. While it was not immediately clear what the effects on this program of the A.M.A. resolution would be, some observers saw it as a warning so sharp and unmistakable that Blue Shield would now have either to openly oppose the A.M.A. or to discontinue the operation of Medical Indemnity of America, Inc. As the dust from the A.M.A. meeting settled, representatives of Blue Shield plans were being called to a meeting to decide what to do.

At the annual public relations institute conducted by the A.M.A. for secretaries and public relations officials of state and local medical societies, Dr. Edwin L. Crosby, director of the Joint Commission on Accreditation of Hospitals, explained what accreditation of a hospital means to the public and hence what it means to the public relations of the medical profession in the community. Appearing on the same panel with Dr. Crosby was Dr. Henry V. Weinert of Passaic, N. J., who described a successful hospital tissue committee program whose reports had been publicized in the community in such a way that public confidence in the hospital and its doctors was strengthened and improved.

Later, the house of delegates approved a resolution requesting official clarification and interpretation of commission requirements, especially in relation to the status of general practitioner sections of hospital staffs, and seeking a procedure through which staffs may appeal commission decisions with which they disagree—a procedure for which commission by-laws provide.



Beauty, Efficiency, Value — Lupton Means All Three

Tri-County Suffolk Health Center, Suffolk, Virginia. Architect: Paul D. Woodward, Norfolk, Virginia. Contractor: Reid & Hope Construction Company, Suffolk, Virginia. Windows: Lupton Architectural Projected Steel.

Simplicity of line, a feature of many contemporary buildings, is echoed with Lupton Metal Windows. Notice, in the Health Center illustrated above, how they blend into the all-over theme to form one architectural whole. Here is perfect beauty, unobtrusive, adaptable . . . and permanent.

These Lupton precision-made windows will never warp, swell, shrink or rattle. Years from now their ventilating units will still operate freely — open easily and close tight. Experience gained in over 40 years of designing and manufacturing metal windows has made it possible to mass-produce a "custom" window that gives years of trouble-free service.

When you think of building — think of Lupton. Here are four windows from the extensive Lupton line that are particularly suited for hospitals. 1) the Master Aluminum Projected Window — there is nothing finer. 2) the Aluminum Awning Window, featuring a center-sill operated closure that insures equalized pull to both sides of the window. 3) the Aluminum Combination Casement with an open-in sill ventilator. 4) and . . . where Steel is preferred, the Steel Architectural Projected Window.

For further details, check with your architect, call the Local Lupton Representative, or write direct.

MICHAEL FLYNN MANUFACTURING COMPANY
700 East Godfrey Avenue, Philadelphia 24, Penna.
Member of the Steel Window Institute and Aluminum Window Manufacturers Association

LUPTON
METAL WINDOWS

NEWS...

A.I.A. Issues Outline of Functions of the Consultant

NEW YORK.—Several years of cooperation in the preparation of an outline of duties of architects and consultants has resulted in the release here last month by the American Institute of Architects of the functions of a consultant, as agreed upon by both groups.

"Functions of the Consultant," A.I.A. Document No. 356 (Rev. June 13-53) appears in full as follows:

FUNCTIONS OF THE CONSULTANT

The Architect of any building has the legal and inescapable responsibility for the design, planning and supervision of construction of that building.

The Owner of any building has the duty to transmit to his Architect the purposes, scope, use pattern, and budget of that building.

The Consultant's primary function is to supplement the Owner's experience and judgment in matters of detail, special equipment, and operational technics, so that the Owner may—with the Consultant's help—transmit a better and more complete program to the Architect. He may also continue to advise the Owner in the carrying out of the program—in terms of building.

The duties of the Consultant should be:

1. Survey community needs to determine the number and type of buildings needed, population trends, areas of growth and decline.
2. Work with the Architect in the development of a written program.
3. Consult with the Architect on functional planning.
4. Review the Architect's preliminary plans.
5. Review final plans and specifications to determine that the program, as well as the intent, of the preliminary drawings and specifications have been properly carried out.
6. Advise and work with the Architect in planning and specifying the service connected and built-in equipment.
7. Assume such responsibility as agreed to for listing all equipment which is nonservice connected or which is not in the building construction contract.
8. Set up administrative pattern for the operation of the building.

Any Architect has the right and duty to supplement his own experience when a problem requires it. This is well established in engineering and similar fields. He may ally himself with Architects equipped to handle special problems or he may recommend employment of a Consultant. In any case the Architect is expected to furnish leadership to all who help plan, and he must take responsibility for the cooperatively produced end product.

The Consultant either (1) *is not*, or (2) *is* a registered Architect.

In case (1), he is any person whose specialized knowledge and experience enable him to add value to the planning of a building project. He has a proper place in the planning process. He should be compensated according to the value of his contribution. Since he is not an Architect, since he is an extension of the Owner, since he cannot relieve the Architect of any liability or obligation to plan the building, he cannot properly be paid by the Architect either directly or by a reduction in fee. His contribution benefits the Owner, supplement-

Your surgeons' hands require the best protection—DIAL!

Hexachlorophene in Dial Liquid Antiseptic Soap assures faster scrub-ups, greater protection!

Here is a superior product that saves time, offers greater protection in operating rooms – Dial Liquid Antiseptic Soap with Hexachlorophene!

Tests have shown that the surgeon who uses a soap containing Hexachlorophene removes in only 3 minutes *more* skin bacteria than he does with a conventional 10-minute scrub-up followed by a germicidal rinse!

Dial Liquid Antiseptic Soap was created by Armour to give your surgeons this greater safety in a mild soap. Both the 20% and Concentrate Dial contain 5% Hexachlorophene, based on soap content—your assurance of truly germicidal protection. See that your surgeons have the best – Dial Liquid Antiseptic Soap, available in 55-gallon drums.

Use DIAL bar soap for nurses and patients, too!

Hexachlorophene is available for nurses and patients in DIAL's famous bar soap. DIAL, even though it contains Hexachlorophene, *costs your hospital no more* than ordinary soaps. It is available in ½ and 2½-ounce sizes, both *wrapped* and *unwrapped*, and ¾ and 1-ounce sizes, unwrapped only. Order DIAL from your Armour salesman today!

ARMOUR *Industrial Soap Department*

Armour and Company • 1355 W. 31st Street • Chicago 9, Illinois

ing the Architect's expected general competence, and he is therefore paid by the Owner above the architectural fee. The Consultant's name should appear on the drawings. The words "Architect" or "Architectural" should not be linked with his name.

In case (2), the Consultant is a person of specialized experience who is also an Architect. The Owner may employ him for any of the phases of case (1), under similar conditions and compensation. And, in addition, he may render phases of architectural service and receive a share of architectural credit; provided that he furnishes complete and usable material, that the working relationship is clearly understood, and above all, that he assumes his full share of liability and obligation. Thus, the relationship is that of associate architects for that part of the work which is a shared architectural burden, and of Consultant to Architect for the programming and other phases described in case (1).

In the interest of effective teamwork, if the Consultant is chosen first, he should have the privilege of recommending for consideration Architects (more than one) but should not have final determination as to who is chosen. If the Architect is chosen first, he should have the same privilege in regard to the selection of Consultants.

The Board of Directors therefore concludes that:

1. The continuing object of the architectural profession is to produce better buildings. Consultants represent a resource toward this objective rather than an adverse interest to the architectural profession.

2. Consultants' specialized experience may be used in the fields of programming and organization of a specialized building type. The Consultant should communicate his advice in any form he sees fit, including schematics, if he wishes. In so doing, the Consultant cannot, of course, relieve the Architect of any part of his responsibility for the quality of the end product unless he himself is a licensed Architect. Whenever the Consultant undertakes to make schematics he should, before presenting them to the owner, advise with the Architect in order that both the Consultant and the Architect will be in agreement on all matters pertaining to planning and space allocation.

When the occasion warrants and the project can be benefited thereby, members may recommend and work with Consultants who agree to and practice the division of duties stated.

(This document was revised and approved by the Board of Directors, A.I.A., June 3, 1953.)

Careers Committee Issues Manual for Recruiters

NEW YORK.—A 68 page, looseleaf book has been prepared by the Committee on Careers of the National League for Nursing as a tool for those engaged in recruiting student nurses, the league announced last month.

Entitled "Manual for Student Nurse Recruiters" the book includes: how to organize a student nurse recruitment committee on local or state level, importance of community representation on the committee, and a definition of duties for each of the volunteer workers. Among the programs listed are speakers' bureaus, liaison work with school counselors, school librarians, women's clubs, and church groups.

An Administrator* Reports...

"Here is what we looked for...here is what we found...here is the answer to why we bought **HOFFMAN** Institutional Laundry Equipment."

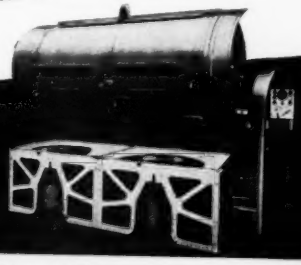
"First and most important was complete assurance of clean and sterilized linen at all times, processed with just the right amount of bleach, softener, soap and starch. Hoffman washers with their accurate controls and superior washing action gave that assurance.

Of almost equal importance were the noise and vibration factors. Site considerations made it mandatory that our laundry be situated in the basement of the building where such considerations might well affect the patients' rest and quiet. The silent chain drive of Hoffman flatwork ironer and the advanced engineering of the extractor offered the ideal solution of these nuisances.

With the ever increasing resistance of the public to rising hospital costs, economy of operation was a prime consideration. Hoffman demonstrated its awareness of the need for such economy, through their engineering assistance in laying out the most efficient machinery setup to meet our particular laundry requirements. This is reflected in our ability to operate our laundry with less personnel than the average hospital of comparable size in the area. The fast-drying action of the Greyhound tumbler, pinpoint control of supplies used, and greater life of linens, due to the easy unloading of the washers, all spell economy of operation.

Twenty-four hours a day, three hundred and sixty-five days a year, the hospital must minister to the needs of its sick and injured. Dependability is the keyword! The experience of these institutions which we visited, with properly installed equipment and maintenance-free operation over long periods of time, and the comforting knowledge of parts and service at a moment's notice (as demonstrated by Hoffman's record throughout World War II) qualified Hoffman as absolutely dependable.

An added bonus not looked for in our original evaluation has been the favorable reaction of applicants for laundry positions when they learn that we are equipped 100% with Hoffman machinery."



*An actual letter in our files. Name on request.

In the HOFFMAN Complete Line of Advanced-Design Laundry Equipment, there are Models to Meet the Exact Needs of Every Size and Type of Institution
CONSULT YOUR HOFFMAN LAUNDRY ENGINEER

INSTITUTIONAL ... DIVISION

Hoffman

U. S. HOFFMAN MACHINERY CORP. 105 FOURTH AVENUE, NEW YORK 3, N. Y.

ABOUT PEOPLE

(*Continued From Page* 91)

Joseph M. DeFilippo has been named assistant administrator of Fitkin Memorial Hospital, Neptune, N.J. Mr. DeFilippo is a graduate of Duke University and holds a master's degree in hospital administration from Northwestern University.

Ernest H. Fiedler has succeeded **Ruth A. Smith** as superintendent of Bartow General Hospital, Bartow, Fla.

O. C. Estes has been named assistant administrator of the Hospital Center, Orange, N.J. A graduate of the University of Oklahoma, he received his master's degree in business administration from the same school. He is a candidate for a master's degree in hospital administration at the University of Chicago.

Glenn M. Reno succeeded **Walter Oliver** as administrator of Children's Hospital, San Francisco. Mr. Reno holds a master's degree in hospital administration from the University of Minnesota.

Sister Mary Madeline, administrator of St. Francis Hospital, Port Jarvis, N.Y., for the last three years, has succeeded **Sister Ann Elizabeth** as administrator of St. Mary's Hospital, Orange, N.J. Sister Ann Elizabeth has been named educational director of the school of nursing at St. Francis Hospital, Poughkeepsie, N.Y.

Arthur L. Joiner has been named business manager of Eugene Wuesthoff Memorial Hospital, Rockledge, Fla., succeeding **John M. Boyer.**

B. V. Culwell, superintendent of Lee Memorial Hospital, Fort Myers, Fla., since 1948, has resigned.

John M. Nicklas, assistant director of the Commission on University Education, has been named assistant director of Roosevelt Hospital, New York City. A graduate of Columbia University, Mr. Nicklas received his master of science degree in hospital administration from Columbia's School of Public Health in 1951, and served his residency at University Hospitals of Cleveland.

Warren W. Simonds, a resident of Barnes Hospital, St. Louis, has been appointed associate director of the hospital.

Sister M. Borromeo succeeds **Sister M. Lelia** as administrator of St. Joseph's Hospital, Bellingham, Wash.

Grace Burket has been named superintendent of Nason Hospital, Roaring Spring, Pa. For the last 18 years Miss Burket has been a member of the staff of Lewiston Hospital, Lewiston, Pa., and in the last several years has been director of the hospital's school of nursing.

Claire King Weiss is the new administrator of Eye, Ear, Nose and Throat Hospital, New Orleans. Formerly, Mrs. Weiss had been the hospital's assistant administrator.

James B. Clemens has been appointed assistant administrator and purchasing officer of Columbia Memorial Hospital, Hudson, N. Y.

W. E. Arnold, administrator of City-County Hospital, McKinney, Tex., since February 1951, is now business manager of Baylor Hospital, Dallas, Tex. Mr. Arnold had been assistant to the administrator and purchasing agent at Wesley Hospital, Oklahoma City, Okla., prior to becoming administrator of the hospital at McKinney.

Henry Amicarella has been appointed administrator of Good Samaritan Hospital, Sandusky, Ohio. Formerly, he

HUNTINGTON

Free HELPFUL BOOKLET . . .

HOW TO REMOVE STAINS from floors

Do you have this new HUNTINGTON AID for your maintenance men?

Here is a booklet your men will find invaluable day after day . . . saving time . . . saving trouble . . . saving expensive floors. It tells how to remove stains from all types of flooring. The methods are easy to understand. Directions are simple to follow. It tells what to do *and what to avoid.* Cleaning materials are described and complete directons for their use are given.

It is a complete and useful handbook of methods that has been needed for years. Now it is yours free on request. There is no obligation. Mail coupon below or write on your letterhead today.

Mail this Coupon Now !

HUNTINGTON HUNTINGTON **LABORATORIES**

HUNTINGTON LABORATORIES, INC., Huntington, Indiana

☐ Please send my copy of the handbook, "How to Remove Stains from Floors."
☐ I would also like to see your representative soon.

NAME _____ TITLE _____

ADDRESS _____

CITY _____ STATE _____

held the position of assistant administrator at Evanston Hospital, Evanston, Ill., and at Colorado General Hospital, Denver.

Ralph B. Bersell has been named administrator of Passavant Memorial Hospital, Jacksonville, Ill., succeeding **Carroll T. Hughes.** For the last three years, Mr. Bersell has been a hospital administrative consultant in the bureau of hospitals of the Illinois Department of Public Health, Springfield. He is a graduate of the course in hospital administration at the University of Minnesota.

Department Heads

Dr. Edward E. Fischel has been named director of medicine at Bronx Hospital, New York City, effective May 1. Following his graduation from the College of Physicians and Surgeons, Columbia University, in 1944, Dr. Fischel served his internship and did his graduate training in internal medicine at Presbyterian Hospital, New York City, where he has since been engaged in teaching and research in the medical center. He is a diplomate of the American Board of Internal Medicine.

Frederick D. Squire, formerly purchasing agent at Oakwood Hospital, Dearborn, Mich., has been appointed purchasing agent of St. Luke's Hospital, Cleveland. Mr. Squire succeeds **Walter N. Lacy,** who has retired after 25 years of service.

J. L. Moore is the new director of the outpatient department at Baylor Hospital, Dallas, Tex. He is a former member of the business office staff.

Ruth K. Moser, director of nursing at St. Luke's Hospital, New York City, since 1946, will become director of nursing at Montgomery Hospital, Norristown, Pa., on March 1. Miss Moser is a graduate of St. Luke's and holds degrees from Columbia University and the University of Chicago.

Miscellaneous

Eleanor A. Hall has been named assistant dean of Yale University's School of Nursing. A member of the faculty since 1948, when she was named assistant professor of nursing education, Miss Hall has been an associate professor at Yale since July 1, 1951.

Margery R. Cunningham has been appointed staff assistant to **Lucille M. Smith,** executive secretary of the National Conference on Care of the Long-Term Patient. For the last two years, Mrs. Cunningham has been an information specialist for the U.S. Public Health Service.

Deaths

Dr. Charles F. Menninger, 91, founder of the Menninger Clinic, Topeka, Kan., and chairman of the board of the Menninger Foundation, died in November.

The Very Rev. John J. Bingham, 55, former director of the department of health and hospitals of New York Catholic Charities, died in November.

Standard Drug Catalogs Now Available

WASHINGTON, D.C.—Printed copies of Simplified Practice Recommendation R250-53, Standard Drug Catalogs, are now available, the Commodity Standards Division of the U.S. Department of Commerce has announced.

With a view to ameliorating the existing confusion, druggists, apothecaries, producers and distributors of pharmaceutical and proprietary products, and hospital officials through their several professional organizations and with the collaboration of the Department of Commerce, voluntarily developed this catalog.

NEWS...

Let Blue Cross Provide Care for Servicemen's Dependents, A.H.A. Urges

CHICAGO.—A recommendation that hospital and medical care for military dependents be provided through Blue Cross and Blue Shield prepayment plans was made last month by the board of trustees of the American Hospital Association, the association has announced.

In making this recommendation the board took a position that is opposed to a proposal by the government's Moulton Commission which suggests that care for dependents be provided by the armed services in military hospitals wherever possible and in civilian hospitals only when military facilities are unavailable.

It was the feeling of the board that such a plan would encourage the building of a large military hospital system at great expense and prevent military dependents from having the privilege of free choice of physician and hospital, an association announcement explained.

Ritz E. Heerman, president of the A.H.A., said dependents could be cared for in presently available civilian hospitals and that the use of prepayment, through the voluntary Blue Cross and Blue Shield plans, was the proper method.

On the basis that it is a policy decision to be made by the government, the board did not take a stand on whether such payment coverage should be purchased for dependents by the government.

California Award Goes to Sr. Mary Philippa

SAN FRANCISCO.—Sister Mary Philippa, R.N., administrator of St. Mary's Hospital, San Francisco, was first recipient of the annual Award of Merit established by the California Hospital Association to recognize distinguished service in hospitals.

The award, voted at the recent association convention in Santa Barbara, was presented to Sister Mary Philippa by William B. Hall, president of the San Francisco Hospital Conference and administrator of the University of California Hospital.

Sister Mary Philippa for the last 30 years has been continuously active in hospital work in San Francisco. She received her training in nursing at St. Mary's and has remained with that institution ever since, the last 10 years as administrator.

COMING EVENTS

ALABAMA HOSPITAL ASSOCIATION, Mobile, Jan. 14, 15.

AMERICAN ACADEMY OF GENERAL PRACTICE, Public Auditorium, Cleveland, March 22-25.

AMERICAN ASSOCIATION OF MEDICAL RECORD LIBRARIANS, Sheraton-Cadillac Hotel, Detroit, Oct. 4-8.

AMERICAN COLLEGE OF HOSPITAL ADMINISTRATORS, Chicago, Sept. 11-13.

AMERICAN HOSPITAL ASSOCIATION, Mid-Year Conference, Chicago, Feb. 5, 6; Navy Pier, Chicago, Sept. 13-16.

AMERICAN PROTESTANT HOSPITAL ASSOCIATION, Palmer House, Chicago, Feb. 10-12.

ARIZONA HOSPITAL ASSOCIATION, Phoenix, Feb. 11-13.

ASSOCIATION OF WESTERN HOSPITALS, Hotel Statler, Los Angeles, April 26-29.

CAROLINAS-VIRGINIAS HOSPITAL ASSOCIATION, Hotel Roanoke, Roanoke, Va., April 29, 30.

CATHOLIC HOSPITAL ASSOCIATION, Convention Hall, Atlantic City, N.J., May 17-20.

INDIANA HOSPITAL ASSOCIATION, Student Union Building, Indiana University Medical Center, Indianapolis, June 10, 11.

IOWA HOSPITAL ASSOCIATION, Annual Meeting, Savery Hotel, Des Moines, April 21.

KANSAS HOSPITAL ASSOCIATION, Wichita, Nov. 12, 13.

KENTUCKY HOSPITAL ASSOCIATION, Hotel Seelbach, Louisville, April 20-22.

LOUISIANA HOSPITAL ASSOCIATION, Baton Rouge, April 29, 30.

MARYLAND-DISTRICT OF COLUMBIA-DELAWARE HOSPITAL ASSOCIATION, Hotel Shoreham, Washington, D.C., Nov. 8, 9.

MASSACHUSETTS HOSPITAL ASSOCIATION, Hotel Statler, Boston, Jan. 26.

MIDDLE ATLANTIC HOSPITAL ASSEMBLY, Convention Hall, Atlantic City, N.J., May 26-28.

MIDWEST HOSPITAL ASSOCIATION, Hotel President, Kansas City, Mo. April 28-30.

NATIONAL EXECUTIVE HOUSEKEEPERS ASSOCIATION, Biennial Congress, Drake Hotel, Chicago, June 2-5.

NEW ENGLAND HOSPITAL ASSEMBLY, Hotel Statler, Boston, March 29-April 1.

NEW YORK STATE DIETETIC ASSOCIATION, Albany, April 29, 30.

OHIO HOSPITAL ASSOCIATION, Hotel Cleveland, Cleveland, Mar. 29-April 1.

SOUTHEASTERN ASSEMBLY OF NURSE ANESTHETISTS, Atlanta, Ga., April 7-9.

SOUTHEASTERN HOSPITAL CONFERENCE, Atlanta, Ga., April 7-9.

TENNESSEE HOSPITAL ASSOCIATION, Hotel Greystone, Gatlinburg, Tenn., May 20-22.

TEXAS HOSPITAL ASSOCIATION, Shamrock Hotel, Houston, May 18-20.

TRI-STATE HOSPITAL ASSEMBLY, Palmer House, Chicago, May 3-5.

UPPER MIDWEST HOSPITAL ASSEMBLY, Hotels Lowry and St. Paul, St. Paul, Minn., May 12-14.

WISCONSIN HOSPITAL ASSOCIATION, Milwaukee, March 18.

TRUSTWORTHY

No business . . . no institution . . . can prosper long without trustworthy employees, or trustworthy equipment. In the hospital this is particularly true. For here you deal with human life.

The fact that for over 70 years countless hospitals have continued to use Ivory Soap offers ample evidence that medical authorities have found Ivory trustworthy. Ivory offers the hospital everything it demands of a soap for patient care. It is superbly pure . . . it lathers richly even in hard water . . . it cleanses the skin thoroughly and agreeably . . . it has no perfume which might offend.

Ivory is truly a valued "assistant" in countless hospitals. You will find it particularly well qualified to serve *your* institution.

Procter & Gamble
CINCINNATI, OHIO

Pure, mild, rich lathering Ivory Soap is available for hospital use in the popular 3-ounce (packed weight) size as well as in four smaller sizes—wrapped or unwrapped.

99 44/100% PURE . . . IT FLOATS

NEWS...

A.S.T.A. Meeting Is Largest in Its History

(*Continued from Page* 156)

Mr. Widman and Mr. Gordon was William A. Gately, executive director of the Hospital Bureau of Standards and Supplies, Inc., who related the history of the bureau's development and told how it is operated to make purchases and provide product and standardization information to its 250 member hospitals located in 33 states.

In another panel discussion on the function of the surgical supply dealer in our method of distribution, representatives of six manufacturing companies explained their selling policies and methods and answered questions from the floor.

As set forth in an initial presentation by George W. Winch, field manager for the hospital division of Johnson & Johnson, the dealer-manufacturer relationship may be defined in the following terms:

The dealer must:

1. Carry adequate stocks to service those accounts the manufacturer cannot handle.
2. Devote a reasonable amount of selling effort to the manufacturer's products.
3. Bid on and supply the manufacturer's products when specified or called for and not deal in any form of substitution.
4. Furnish a fair share of a manufacturer's products on all unspecified orders.
5. Allow sales representatives to assist in maintaining adequate inventories.
6. Respect the manufacturer's policies.

The manufacturer's functions were outlined as follows:

1. Distribute through authorized dealers.
2. Provide quality products.
3. Provide for a margin of profit commensurate with competitive activity, stock turnover and services performed.
4. Develop new products and improve present products.
5. Provide nationwide sales support.
6. Provide product and sales training for dealer personnel.
7. Handle technical problems beyond scope of dealer organization.
8. Be mindful of inventories and strive toward minimum stock with maximum turnover, without back orders.

In addition to Mr. Winch, others taking part in the manufacturers' panel were: R. H. Brown, Becton, Dickinson & Co.; H. R. Shampaine, Shampaine Co.; J. H. Webb, DePuy Mfg. Co.; Chapin Coit, Hard Mfg. Co., and H. L. Willits, C. R. Bard, Inc. The concluding feature of the convention was an address by Ben F. Hirsch of Davis & Geck, who was celebrating the fiftieth anniversary of his entrance into the surgical supply business. In a speech of reminiscences, Mr. Hirsch recalled A.S.T.A. problems and conventions of earlier years, and predicted that the group would grow far beyond its present stature during the years to come.

Navy Will Build New 1000 Bed Hospital

SAN DIEGO, CALIF.—Construction of a 1000 bed naval hospital has been approved by naval authorities, it was announced here last month by Welton Becket and Associates, architects of the project.

The new unit will be an addition to the existing naval hospital facilities here and is to be devoted primarily to surgery and preoperative and postoperative patient care. Cost of the addition is approximately $7,500,000.

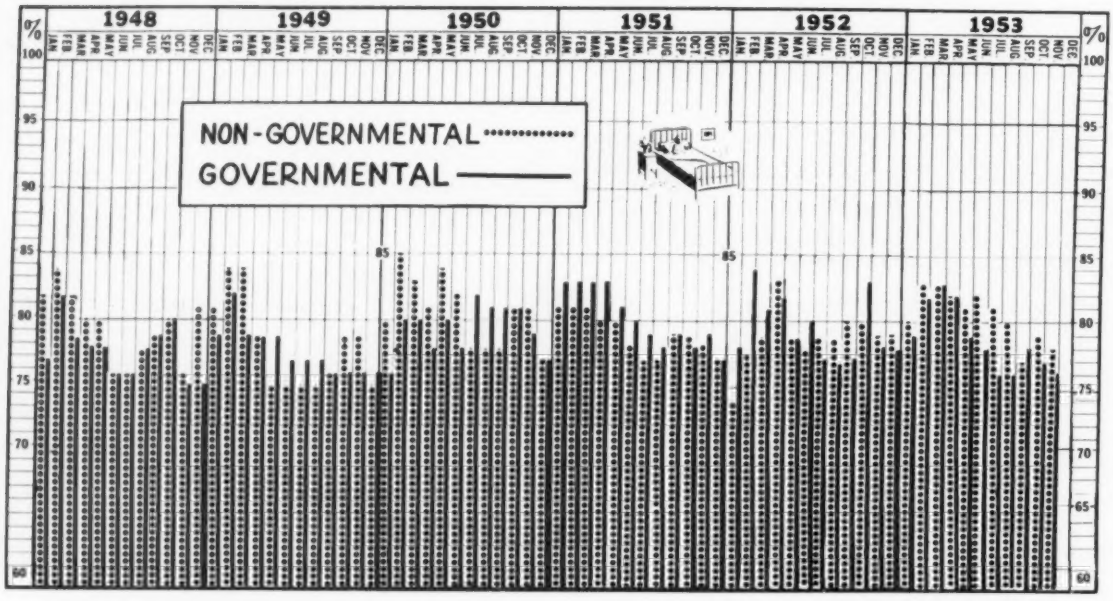
The building, contemporary in design, will be constructed of reinforced concrete. When completed, it will have six floors and three basements. Because it is situated in a canyon, two of the basements will have daylight—the other will be subsurface.

The third basement will house the operating rooms and other facilities necessary for surgery, and a bone bank. In the second basement will be the central supply unit and the hospital's emergency operating facilities. A galley, capable of serving 6000 meals a day, a diet kitchen, vegetable preparation facilities, employes' lockers and a loading platform are planned for the first basement.

Public entry, a lobby, visitors' waiting rooms and an information center are on the main floor, which is also the location of bedrooms and wards.

The remaining five floors will contain bedrooms and wards with each ward having a solarium. Nurses' stations, supply rooms and linen service will be incorporated in the design of each of the patient floors.

1953 Construction Exceeds Last Year's Total



Government hospitals reporting to the Occupancy Chart for the month of November were filled to 76.3 per cent of capacity. Nongovernment hospitals reported an average daily occupancy of 78.4 per cent. Last year, the occupancies reported were 78.7 and 80.2 per cent, respectively for November.

From November 11 to December 14, construction totaled $32,359,067, bringing the total of hospital building for the year to $662,620,805. The figure reported for the comparable period in 1952 was $69,641,824. The total for the year to date at this time last year was $642,527,565. Of the current projects, eight were hospitals and 16 were additions.

For the ultimate in economy, beauty and quality...
for your hospital furniture—look to Englander and Royal

Englander
SLEEP PRODUCTS

1 COMPLETE SERVICE
FROM 2 GREAT NAMES

Royal
metal furniture
since '97

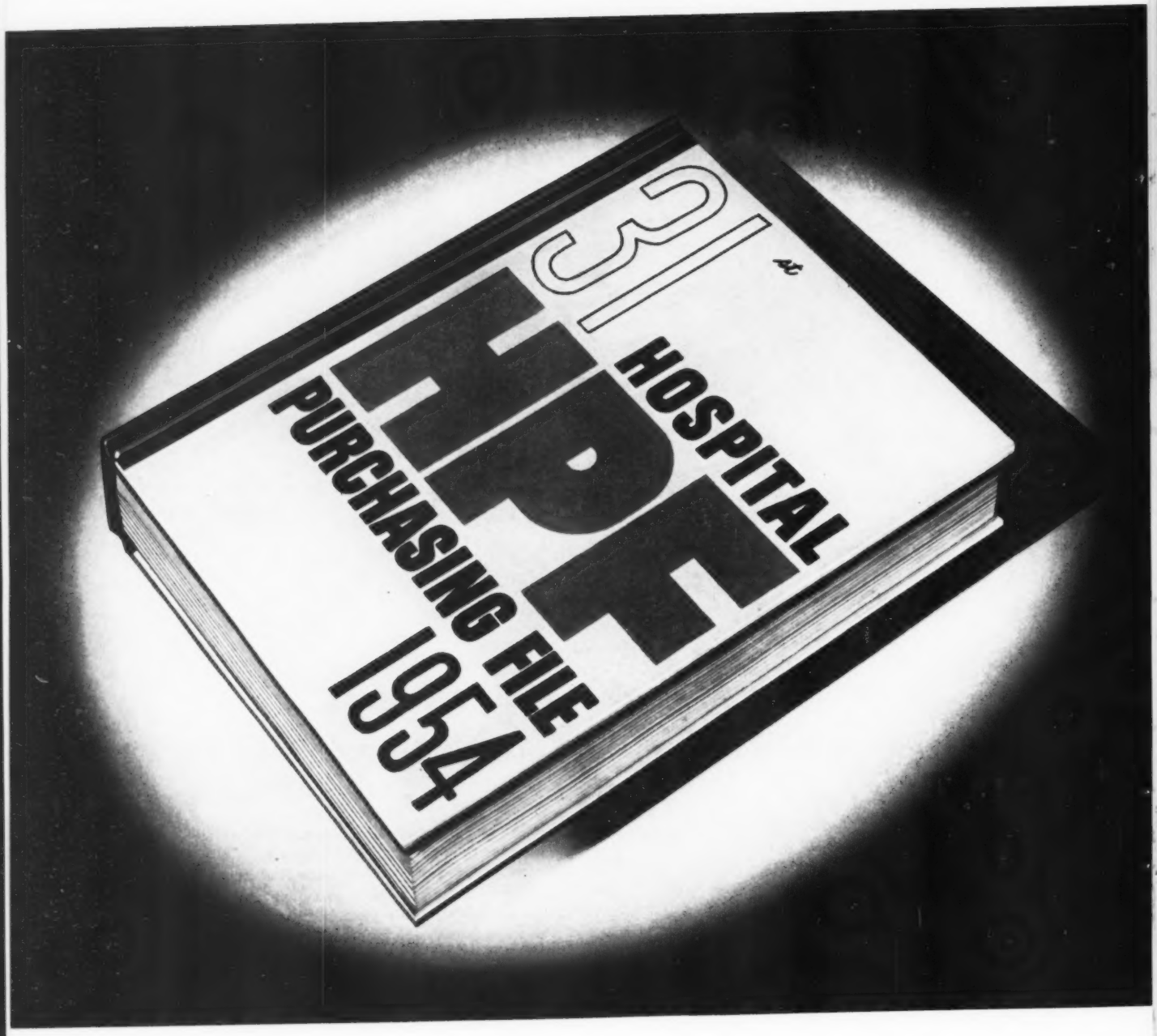
Here is one of the Englander hospital beds with Trendelenberg gatch springs and hospital mattress, selected by the Villa View Hospital, San Diego, California. Also a part of the Englander line are bed frames, head boards, fold-a-ways, bunk beds, sofas, hotel beds, springs and the famous, exclusive Red-Line* Foundation mattress with Goodyear Airfoam**.

Englander, the acknowledged leader in quality sleep products . . . and Royal, the top quality line in metal furniture, now, together offer you one complete line of institutional furniture, available through either company. See your Englander or Royal dealer today!

*TM The Englander Company, Inc.
**TM The Goodyear Tire and Rubber Company

The Englander Co., Inc., Contract Dept., 1720 Merchandise Mart, Chicago 54, Ill. • Royal Metal Manufacturing Co., 175 N. Michigan Ave., Chicago 1, Ill.

COMING



IN JANUARY

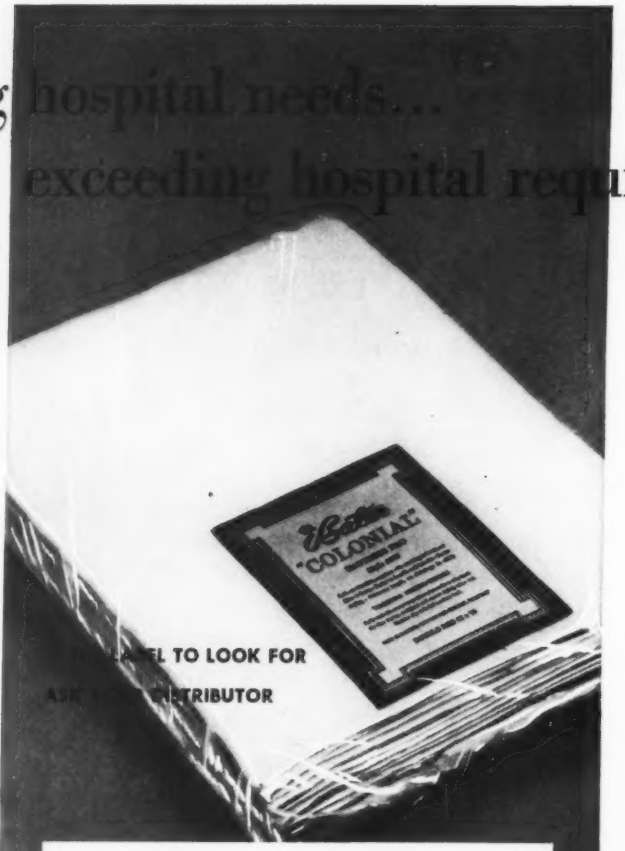
The new 31st edition of *Hospital Purchasing File* will be ready for distribution this month. It will be distributed without charge to all hospitals having more than twenty-bed capacity. Look for it, examine it, learn to use it. In this new edition 275 manufacturers have placed 730 pages of catalog information at your disposal to help you in every routine needed for information about products . . . as always it will have the classified list of hospital products with their suppliers—plus an alphabetical list of all the firms you may want to buy from—plus a wealth of reference information in the back . . . Be sure you keep HPF where it will always be available to you and accessible to your department heads. Teach them to use it too. Rely on *Hospital Purchasing File* first for product information. Look for your copy of the new 31st edition in January.

ESTABLISHED AS THE HOSPITAL YEAR BOOK IN 1919 BY THE MODERN HOSPITAL PUBLISHING CO. INC.

PURCHASING FILES, INC.

919 N. MICHIGAN AVE., CHICAGO 11, ILL.

Meeting hospital needs... exceeding hospital requirements...



EL TO LOOK FOR

TRIBUTOR

Bates

NEW

"COLONIAL"

FINE COTTON MATTRESS PAD

New bleached cotton felt pad is seamless, all one piece. **Wears longer:** no stitching to break, no filling to lump. Soft and comfortable, clings to mattress, helps keep bottom sheet tucked in. **Less bulky:** easier to store, handle, launder, dry, keep sanitary. Bias bound, all four sides. Generous length, no shrinkage in width. Can be washed at any temperature.

STYLE 1302

Sizes 17 x 18, 26 x 34
12 dozen to carton, 1 dozen to package
Sizes 38 x 72, 38 x 76, 52 x 76
3 dozen to carton, ½ dozen to package

BATES FABRICS, INC., 80 WORTH STREET, NEW YORK 13
BOSTON • CHICAGO • ATLANTA • ST. LOUIS • LOS ANGELES

ARIZONA
LEDBETTER DRY GOODS CO.
246 South First St., Phoenix

CALIFORNIA
ALLEN BROS.
900 S. Los Angeles St., Los Angeles
AMERICAN HOSPITAL SUPPLY CORP.
100 East Graham Place, Burbank
AMERICAN HOSPITAL SUPPLY CORP.
767 Mission Street, San Francisco
H. W. BAKER LINEN CO. OF CALIF.
754 S. Los Angeles St., Los Angeles
W. A. BALLINGER & CO.
30 Oaths St., San Francisco
HALE BROS.
706 Mission St., San Francisco
PATEK & CO.
1900 — 16th St., San Francisco
STANLEY ROSENTHAL & CO.
283 Ellis St., San Francisco
WINNIE & SUTCH
659 Mission St., San Francisco

COLORADO
GULDMAN LINEN CO.
1254 Broadway, Denver
A. D. RADINSKY & SONS
2000 W. Colfax Ave., Denver

CONNECTICUT
MAYTEX FABRICS CO.
112-114 Allyn St., Hartford

DISTRICT OF COLUMBIA
AMERICAN HOSPITAL SUPPLY CORP.
3165 B Street North, Washington
R. MARS, THE CONTRACT CO.
410 First St., S. E., Washington

FLORIDA
BENTLEY-GRAY DRY GOODS CO.
916 Twiggs St., Tampa
GEORGE ENGLISH COMPANY
202 S. Atlantic Ave., Daytona Beach
THE MAXWELL CO., INC.
1035 N. Miami Ave., Miami

GEORGIA
AMERICAN ASSOC. COMPANIES, INC.
451 Stephens St., S. W., Atlanta
AMERICAN HOSPITAL SUPPLY CORP.
Chamblee
JOHN W. LUNDEEN
47 Mangum St., S. W., Atlanta
SOUTHEASTERN TEXTILE CO.
222 E. Solomon St., Griffin
UNITED COTTON GOODS, INC.
Griffin

ILLINOIS
AMERICAN HOSPITAL SUPPLY CORP.
2020 Ridge Ave., Evanston
THE BURROWS CO.
325 Huron St., Chicago
CLARK LINEN & EQUIPMENT CO.
303 W. Monroe St., Chicago
FUERSTENBERG & CO.
21 Hubbard St., East, Chicago
HARRIS HOSPITAL SUPPLY, INC.
1400 Washington Blvd., Chicago
L. B. HERBST CORP.
325 N. Wells St., Chicago
KAROLL'S INC.
32 N. State St., Chicago
THEODORE MAYER & CO.
305 W. Adams St., Chicago
WALTER H. MAYER & CO., INC.
325 W. Monroe St., Chicago
MILLS HOSPITAL SUPPLY CO.
6626 N. Western Ave., Chicago
MORTON TEXTILES, INC.
23 S. Franklin, Chicago
ALBERT PICK CO., INC.
2159 Pershing Road, Chicago
WELLMAN & CANAVAN, INC.
549 W. Washington Blvd., Chicago

KANSAS
JOHNSTON & LARIMER, INC.
720 E. Zimmerly St., Wichita

LOUISIANA
LEE DRY GOODS COMPANY
Market & Crockett Sts., Shreveport

MARYLAND
M. AMBACH CO.
20 W. Redwood St., Baltimore
STANDARD TEXTILE CO.
106 Hopkins Place, Baltimore

MASSACHUSETTS
BARTLETT-COPPINGER-MALOON CO.
57 Bedford St., Boston
BOSTON TEXTILE CO.
93 Summer St., Boston
FARLEY HARVEY CO.
115 Kingston St., Boston
JENNINGS LINEN CO., INC.
76 Essex St., Boston
U. S. BEDFORD TEXTILE CO.
91 Essex St., Boston

MICHIGAN
KUTTNAUER MFG. CO., INC.
2189 Beaufait Ave., Detroit

MICHIGAN (CONT.)
McCONNELL-KERR CO.
350 E. Jefferson Ave., Detroit

MINNESOTA
AMERICAN HOSPITAL SUPPLY CORP.
426 Washington Avenue North, Minneapolis
JOESTING & SCHILLING
379 Silbey St., St. Paul
PINK SUPPLY CO.
735 N. Third St., Minneapolis

MISSOURI
AMERICAN HOSPITAL SUPPLY CORP.
512 East 12th Avenue, North Kansas City
FITTS DRY GOODS CO.
407 West 8th St., Kansas City
KANSAS CITY WHITE GOODS MFG. CO.
1819 Baltimore Ave., Kansas City
RICE STIX, INC. (pads only)
1002 Washington Blvd., St. Louis

NEBRASKA
DIETERICH FIELD, INC.
800 P Street, Lincoln

NEW JERSEY
FISHER-COHEN CO.
236 High St., Newark

NEW YORK
AMERICAN HOSPITAL SUPPLY CORP.
40-05 168th Street, Flushing
E. E. ALLEY CO.
46 White St., New York
H. W. BAKER LINEN CO.
315 Church St., New York
BUFFALO HOTEL SUPPLY
189-199 Van Rensselaer St., Buffalo
JAMES H. DUNHAM & CO., INC.
345 Broadway, New York
JAMES G. HARDY & CO.
11 E. 26th St., New York
INSTITUTIONAL PRODUCTS CORP.
161 Sixth Ave., New York
NESTEL PRODUCTS CO., INC.
339 Broadway, New York
READE SUPPLY CORP.
241 Church St., New York
SUPERIOR LINEN CO.
410 Broadway, New York
SUPERIOR MERCANTILE CO.
576 Broadway, New York

NORTH CAROLINA
CAROLINA ABSORBENT COTTON CO.
Div. Barnhardt Mfg. Co., Inc., Charlotte

OHIO
RYAN & GLASGOW, INC.
1375 E. 21st St., Cleveland
STANDARD TEXTILE CO., INC.
628 Sycamore St., Cincinnati

OKLAHOMA
JOHNSTON & LARIMER, INC.
Oklahoma City

OREGON
DENNIS UNIFORM CO.
105 S. E. Hawthorne Blvd., Portland
ARCHIE GOLDSMITH & BROS.
20 N. W. Fifth Ave., Portland

PENNSYLVANIA
JOHN W. FILLMAN & CO.
1020 Filbert St., Philadelphia
PENN DRY GOODS CO.
1001 Filbert St., Philadelphia
RHOADS & CO.
401 N. Broad St., Philadelphia

RHODE ISLAND
TAYLOR SYMONDS CO.
18 Pine St., Providence

SOUTH CAROLINA
QUALITY TEXTILES, INC.
301 Calvin St., Greenville

TENNESSEE
THE ALAMO CO.
58 South Second St., Memphis
WM. R. MOORE DRY GOODS CO.
3rd St. & Monroe Ave., Memphis

TEXAS
AMERICAN HOSPITAL SUPPLY CORP.
2503 Butler Street, Dallas
A. B. FRANK CO.
Merchants Bldg., San Antonio
RICE STIX, INC.
708 Jackson St., Dallas
SOLOMON, SHAPIRO & GLICK CO.
1901 Capitol Ave., Houston

UTAH
PATRICK DRY GOODS CO.
163 W. 2nd South St., Salt Lake City

WASHINGTON
H. W. BAKER LINEN CO.
1101 E. Pike St., Seattle
BOLD LINEN CO.
1008 Western Ave., Seattle

WISCONSIN
WILL ROSS, INC.
4283 N. Port Washington Rd., Milwaukee

classified advertising

TERMS: 20c a word—minimum charge of $4.00 regardless of discounts. No charge for "key" number.
Ten per cent discount for two or more insertions without changes of copy. Forms close 15th of month.

POSITIONS WANTED

ADMINISTRATOR, ASSISTANT, OR BUSINESS MANAGER—Many years progressively responsible experience in hospital and clinic administration; have strong business management engineering ability and background; necessary educational and professional affiliations; proven record of capability, experience handling all non-medical phases of administration; looking for position offering growth and challenge, no sinecure; if you will reward me for handling tough situations, you will find me competent; family; age 36; excellent references. Reply, MW 23, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11.

ADMINISTRATOR — Available February 15; experienced all phases hospital administration, professional management, group practice organization, accounting, credit collection control, consultation; member A.C.O.H.A. Write, MW 24, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11.

The Medical Bureau

M. BURNEICE LARSON—DIRECTOR

PALMOLIVE BUILDING CHICAGO

ADMINISTRATOR — Physician, well trained and well experienced; M.D., M.S., Hospital Administration, leading universities; administrative internship and two years, assistant administrator, teaching hospital; five years, director, large teaching hospital.

ADMINISTRATOR—M.B.A., Hospital Administration; administrative residency and three years, assistant administrator, large teaching hospital; six years, director, 300-bed general hospital.

ADMINISTRATOR—B.S., Nursing; M.B.A., Hospital Administration; three years, director of nurses, university hospital; six years, assistant administrator, 450-bed hospital.

BIOCHEMIST—Ph.D.; three years' teaching; four years, biochemist, 400-bed hospital.

PATHOLOGIST—Diplomate; FCAP; eight years, director, department, 300-bed hospital, on faculty medical school.

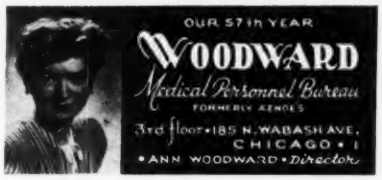
PERSONNEL DIRECTOR—M.A.; six years, personnel director in industry; three years, personnel director, 350-bed hospital.

PHARMACIST—B.S. in Pharmacy; five years, staff pharmacist, teaching hospital.

PURCHASING AGENT—Seven years, purchasing agent in industry; eight years, purchasing agent 300-bed hospital.

RADIOLOGIST—Training in radiology, teaching center; three years, assistant radiologist, large teaching hospital; four years, director, department, 300-bed hospital; Diplomate.

SOCIAL WORKER—M.S., Social Work; eight years' experience, public and private agencies; three years' university teaching.



ADMINISTRATOR — Lay; B.A., Master's, Hospital Administration; 4 years, assistant director, large university hospital; past year, director, voluntary general hospital, 250 beds; also faculty member, medical school; member, ACHA; middle thirties.

ADMINISTRATOR Medical; 5 years, assistant director, university hospital; 5 years, director, very important medical center; FACHA.

ADMINISTRATOR Graduate nurse; past 8 years, director, 350-bed voluntary general hospital; outstanding record of achievement; FACHA.

ANESTHESIOLOGIST — Diplomate; past 6 years, director, anesthesia, important university hospital.

EDUCATIONAL DIRECTOR — Well qualified as coordinator or instructor advanced nursing program; B.S., M.A., Education; middle forties.

INSTRUCTOR — B.S., M.A., Ph.D.; well qualified in theory, medical-surgical; pediatric; psychiatric; 5 years, director nurses; 3 years, instructor, large teaching hospitals; late 40's; New York area only.

PSYCHIATRIC INSTRUCTOR — SUPERVISOR. A.B.; 13 years experience in some of country's best teaching hospitals; consider any locality; age 41.

PATHOLOGIST — Degrees, leading eastern schools; 3 years, pathologist, important teaching hospital and assistant professor, pathology, university medical school; Diplomate, both branches; late 30's.

RADIOLOGIST—Trained university hospital; early 30's; AOA; past year, associate radiologist, general hospital 400 beds; seeks directorship, preferably with part-time teaching; Diplomate, both branches.

INTERSTATE MEDICAL PERSONNEL BUREAU

Miss Elsie Dey, Director
332 Bulkley Building
Cleveland, Ohio

ADMINISTRATOR—B.S. Degree; 17 years, administrator, 150-bed Illinois hospital; 5 years, 70-bed Ohio hospital; experienced hospital consultant.

ADMINISTRATOR—5 years, manager, eastern clinic; 8 years, administrator, 200-bed hospital.

ASSISTANT ADMINISTRATOR — 30 years; M.P.H. Degree; 2 years, administrative resident and assistant, 300-bed hospital; previous banking experience.

BUSINESS MANAGER—17 years public accountant; 9 years, administrative officer, government hospitals; 4 years, business manager, 700-bed hospital.

(Continued on page 190)

INTERSTATE—*Continued*

COMPTROLLER—M.B.A. Degree, 1946, Business Managing; 5 years, member accounting firm; 3 years assistant controller, 500-bed hospital, New England; available.

EXECUTIVE HOUSEKEEPER—B.A. Degree, southern college; hotel housekeeper, 3 years; present position, executive housekeeper, 300-bed eastern hospital.

POSITIONS OPEN

ANESTHETIST—Moving to Milwaukee? Position for nurse anesthetist in 350-bed teaching hospital with residents and interns; present staff of eight nurse anesthetists and three medical anesthetists; work averages 32 hours per week plus 24 hours additional on call; salary open; month's vacation with pay; other benefits. Apply to: Administrator, Milwaukee Hospital, 2200 West Kilbourn Avenue, Milwaukee 3, Wisconsin.

ANESTHETIST Registered nurse, with two or more years' experience, for 200-bed hospital on Florida's Gulf Coast; medical anesthesiologist in charge of department; good salary, living quarters; yearly vacation and sick leave. Write to MO 67, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11.

ANESTHETIST—Nurse; for 250-bed general hospital; excellent working conditions and personnel policies; good starting salary. Write, Robert M. Jones, Assistant Administrator, Columbia Hospital, 3321 North Maryland Avenue, Milwaukee 11, Wisconsin.

ANESTHETIST — Nurse; modern 115-bed, acute general hospital; department in charge of certified medical anesthetist; salary open. For particulars, write Director, Department of Anesthesiology, Mount Sinai Hospital, Hartford, Connecticut.

ANESTHETIST — Nurse; established private clinic and hospital; Florida Gulf Coast, rapidly growing resort; a fine place to live; $400 monthly with meals; full pay vacation. Apply, Administrator, Adams Hospital, Inc., Panama City, Florida.

ANESTHETIST—Nurse; starting salary $325 plus complete maintenance and $10 each night on call; on call duty four to six nights monthly; eight nurse anesthetists on staff; three weeks' vacation and twelve sick leave days per year; automatic annual pay increase and bonus. Apply, Mrs. F. Stowe Burwell, Charlotte Memorial Hospital, Charlotte, North Carolina.

DIETITIAN Staff; 165-bed private general hospital with young staff; conveniently located in medium-sized city; prefer ADA membership; no experience necessary; some therapeutic and some administrative work on staff of three; 40-hour week; newly remodeled kitchen; salary open, meals, laundry, insurance furnished. Apply Personnel Director, Flower Hospital, Toledo, Ohio.

DIETITIAN—For 100-bed hospital; salary depends on experience and qualifications. For particulars apply, Superintendent, Soldiers' Memorial Hospital, Campbellton, New Brunswick, Canada.

DIETITIAN—Therapeutic; good salary; 225-bed hospital, school of nursing; central food service. Contact Personnel Director, Riverside Hospital, Newport News, Virginia.

classified advertising

POSITIONS OPEN

DIETITIANS—Department of Health, General Hospital (475 beds), St. John's, Newfoundland, invites applications for the following posts: (1) A Chief dietitian to take charge of the dietary department; salary $3000 per annum on the scale of $3000-100-3300; this post is a civil service appointment and is pensionable (non-contributory); 5-day working week, 4 weeks annual leave on full pay plus statutory holidays, generous sick leave, etc. (2) Dietitians to work under supervision of the chief dietitian; salary $2800 per annum on the scale $2800-100-3000; pensionable posts (non-contributory); 4 weeks annual leave on full pay, 8-hour day, straight shifts, 44-hour week, with all statutory holidays, generous sick leave, etc.
Traveling expenses to St. John's for candidates appointed will be paid by the Department of Health. Applications stating qualifications, experience, etc., with full details, together with two names for reference should be sent immediately to: E. Wilson, M.D., Superintendent, General Hospital, St. John's, Newfoundland.

DIETITIANS—Therapeutic dietitians; Barnes Hospital, large teaching hospital; 3 units affiliated with Washington University School of Medicine; beginning salary $270 month; social security. Apply, Director of Dieteties, Barnes Hospital, 600 South Kingshighway, St. Louis 10, Missouri.

DIETITIANS—Therapeutic; for 275-bed teaching hospital; Chicago lake front area; must be A.D.A. member; white; begin at $310 month, salary adjustment for experience; 40-hour week; 3 weeks vacation, 4 weeks at the end of 2 years; Blue Cross, pension plan, social security, 12 days paid sick leave per year and annuity; 50% tuition reduction on courses at Northwestern University. Write, Passavant Hospital, Personnel Department, 303 East Superior Street, Chicago 11, Illinois.

DIRECTOR—Clinical; for a 30-bed, private psychiatric hospital, fully equipped for diagnostic work plus outpatient clinic; minimum starting salary $12,000. Reply, MO 68, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11.

DIRECTOR—Assistant administrative services; positions at both divisions of large general hospital; two years large hospital experience and M.H.A., or equivalent, required; salary $6480-$8140. Contact, Personnel Officer, Philadelphia General Hospital (Northern Division) Front and Luzerne Streets, Philadelphia 40, Pennsylvania.

DIRECTOR OF NURSES—Assistant; in a 441-bed institution located in Delaware; Degree in Nursing Education required; salary depends upon qualifications and experience; maintenance and apartment included. Apply to Director of Nurses, Delaware Hospital, Wilmington, Delaware.

DIRECTRESS OF NURSES—300-bed fully approved general hospital with accredited school of nursing; located in a beautiful resort city; personnel policies in accordance with S.N.A.; Degree in Nursing Education required; full maintenance; salary open. Apply, Atlantic City Hospital, Atlantic City, New Jersey.

ASSOCIATE DIRECTOR OF NURSING SERVICE—For a 300-bed general hospital; forty-five minutes from New York City; 40-hour week; cooperative staff; opportunity to develop many areas; salary open. Apply, MO 64, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11.

INSTRUCTOR—Clinical; registered nurse for teaching theory and practical aspects of nursing arts and science within clinical areas of hospital; paid benefits, excellent working conditions, living accommodations available. Write Personnel Office, The Jewish Hospital, Cincinnati 29, Ohio.

INSTRUCTOR—Medical clinical; in 225-bed hospital; 130 students in the school of nursing; assume full responsibility for classroom and ward teaching; 40-hour week, 4 weeks paid vacation, 7 paid holidays, sick leave accumulative to 30 days; salary open. Apply, Tacoma General Hospital School of Nursing, 314 South K Street, Tacoma, Washington.

INSTRUCTOR—Of nurses; wanted immediately; salary open. Apply, Miss A. G. Cameron, Acting Superintendent, Prince County Hospital, Summerside, Prince Edward Island, Canada.

(Continued on page 192)

classified advertising

POSITIONS OPEN

INSTRUCTOR—Science; approved school of nursing has excellent opportunity for qualified science instructor; fine, modern equipment; living accommodations available; salary open; pension plan; travel arrangements for interview. Apply to Personnel Director, The Christ Hospital, 2139 Auburn Avenue, Cincinnati, Ohio.

INSTRUCTORS—Clinical; in the medical and surgical areas; 332-bed hospital located in an attractive residential section; student body of 160; Degree in Nursing Education and some teaching experience preferred; salary range for 40-hour week $320-$430; beginning salary commensurate with experience and preparation; liberal personnel policies; living accommodations available. Apply to Director of Nursing, The Toledo Hospital, Toledo 6, Ohio.

INSTRUCTORS—Nursing arts instructor and Clinical instructor; 225-bed hospital; 90 students, 3-year course; 30 students admitted each year; insurance plan; social security; liberal vacation; degree required; salary arrangements open for negotiation; travel allowance. Apply, Director Nursing Education, or Administrator, Bismarck Hospital, Bismarck, North Dakota.

LIBRARIAN—Registered medical record; to head department of 635-bed voluntary nonprofit J.C.A.H. approved teaching hospital; approximately 25,000 discharges annually, plus 45,000 visits outpatient department; medical staff all board certified; department 26 employees and consequently requires a person with exceptional organizational administrative ability; active medical record and tissue committee; standard nomenclature and unit number system; salary open but commensurate with size of department and the experience and ability of applicant. Apply, Director, Harper Hospital, Detroit 1, Michigan.

NURSES—General duty; 100-bed general hospital, alternating shifts. Address Director of Nurses, Martinsville General Hospital, Martinsville, Virginia.

NURSES—General duty; for 250-bed private hospital overlooking the San Francisco Bay; minimum salary $275 per month for 40-hour, 5-day week; automatic increases, paid vacation, sick leave, seven holidays per year, prepaid medical-surgical insurance plan, social security; $10 differential for P.M. or night shift; temporary housing available; necessary to secure temporary California permit. Address, Director of Nursing, Samuel Merritt Hospital, Oakland, California.

NURSES—Graduate; for new 50-bed general hospital in thriving village, Catskill Mountains; 8-hour day, 6-day week, time-and-one-half for overtime after 40 hours, rotating shifts; average gross cash salary $200 to $210 month; full maintenance available for $10.50 week. Apply, Superintendent Nurses, Margaretville Hospital, Margaretville, New York. Phone Margaretville 50.

NURSES—Assistant head nurses; registered; due to expanding facilities, openings available in all areas—surgical, medical, obstetrics, etc.; living accommodations available; paid benefits. Write Personnel Office, Jewish Hospital, Cincinnati 29, Ohio.

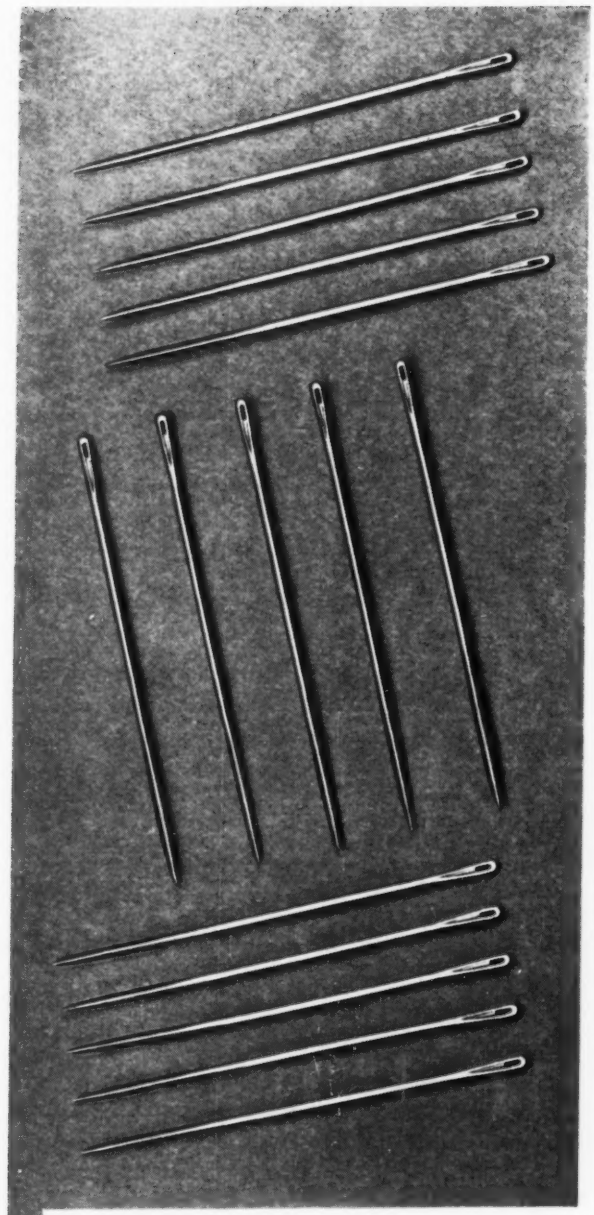
NURSES—Registered; for staff positions; liberal personnel policies; 40-hour week; salary $2912 to $3328; regular increments; day nursery for children of nurses; fully approved; college affiliation; near New York and accredited universities. St. Barnabas Hospital, 685 High Street, Newark, New Jersey.

NURSES—Registered; for active 50-bed general hospital, 100 miles northwest of Toronto; salary $155 per month plus full maintenance. For further information, write or phone Superintendent, Memorial Hospital, Listowel, Ontario, Canada.

NURSES—Two, operating room; 60-bed general hospital, college town, 10,000; 45-hour week; vacation, sick leave, social security; rooms available in residence; minimum $250 per month, extra compensation for emergency cases. Apply to Superintendent, Jane M. Case Hospital, Delaware, Ohio.

NURSES—Operating room and obstetrical; California hospital on San Francisco Bay; forty minutes from that city; 5-day week; salary $275 per month if applicant has advanced preparation or experience; $10 additional for evening and night duty; maintenance available. Director of Nursing, Alameda Hospital, Alameda, California.

(Continued on page 194)



TEMPERED FOR EXTRA STRENGTH
by special heat treating methods

TORRINGTON stainless steel surgeons needles

Order from your hospital supply dealer. Catalog on request.

THE TORRINGTON COMPANY, Torrington, Conn.
Specialists in Needles since 1866

SAVE YOUR FLOORS

from SCRATCHING, MARRING, GOUGING

Any floor keeps its good looks far longer when you equip hospital beds, laundry hampers, screens, bedside tables and service carts with Bassick "Diamond-Arrow" casters or rubber-cushion glides.

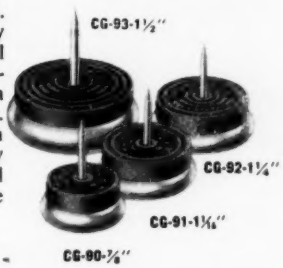
That means lower floor maintenance costs. It also means nurses and attendants have an easier time because these Bassick casters make anything that's mobile roll easily, safely and quietly.

"DIAMOND-ARROW CASTERS"

Easy-rolling casters with soft rubber tread that can't harm floors. Double ball-bearing construction for faster swivelling. Electrically conductive wheels supplied where needed. Stems and adapters for every type of equipment. (Caster shown has Bassick rubber expanding adapter for tight grip in bed legs.)

RUBBER-CUSHION GLIDES

Smooth-sliding and quiet. Broad flat base of highly polished, hardened steel glides easily over any surface. Live-rubber cushion absorbs noise and bumps. Easily attached to wooden furniture legs by simply driving in nail. Special adapters furnished for use with metal tubing legs.



THE BASSICK COMPANY,
Bridgeport 2, Conn.
In Canada: Belleville, Ont.

Check Hospital Purchasing File for other Bassick floor-protection equipment

Bassick
A DIVISION OF
STEWART SW WARNER

MAKING MORE KINDS OF CASTERS... MAKING CASTERS DO MORE

75 YEARS OF CASTER LEADERSHIP

classified advertising

POSITIONS OPEN

NURSES—Staff and operating room; 5 days, 40 hours; 8 holidays and vacation with pay; initial salary $250 plus laundry; increases at 6, 12, 24, 36 months; additional pay for evening and night assignments and for operating room calls. Apply, Director of Nursing, St. Luke's Hospital, New York 25, New York.

NURSES—General staff; 250-bed general hospital and 72-bed maternity hospital; starting salary $280; $5 per month tenure increase for each six months of service to a maximum of $310; social security, sick leave, prepaid medical and hospital care; $10 additional for afternoon and night shift; $10 additional for delivery room; $20 additional for surgery; up to three weeks' vacation at end of 4 years; 7 paid holidays; 8-hour day, 40-hour week. Apply to Director of Nurses, Sutter Hospital, Sacramento, California.

NURSES—Staff positions open; liberal policies; will soon occupy beautiful new 600-bed hospital; opportunity for advanced study in nearby university. Write, Director of Nursing, Miami Valley Hospital, Dayton 9, Ohio.

NURSES — Surgery nurses: Assistant head nurses; $250 per month for 40-hour week, $272 for 44-hour week. Write, Superintendent, Doernbecher Memorial Hospital for Children, Unit of University of Oregon Medical School, Portland, Oregon.

NURSES—General staff, primarily interested in maternity or gynecologic nursing; opportunity for stimulating experience in a university hospital; cultural and recreational facilities of the university available to the nursing staff; 40-hour week; beginning salary $300 per month with $1 per day differential for evening or night duty; permanent evening or night duty $40 per month differential; opportunity for advancement; excellent physical plant, beautifully equipped; attractively furnished housekeeping apartments available at $35 per month shared Apply, Director of Nurses, University of Chicago, Lying-in Hospital, 5841 Maryland Avenue, Chicago 37, Illinois.

NURSES—General staff; for new 32-bed hospital opened 2 years; liberal salary; excellent working conditions. Apply, Administrator, Wells Municipal Hospital, Wells, Minnesota.

SECRETARY—Medical; for 180-bed hospital in midwestern city of 200,000; knowledge of medical terminology; takes dictation of medical reports and letters, prepares periodic reports, maintains files, part-time records librarian, performs related clerical duties; pleasant surroundings; paid vacations; salary commensurate with experience and qualifications. Reply, MO 54, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11.

SUPERVISOR—Floor; adult patients, medical and surgical; 150-bed hospital, school of nursing; salary open. Contact Ruth Brant, Martins Ferry Hospital, Martins Ferry, Ohio.

(Continued on page 196)

SUPERVISOR—Medical clinical; 215-bed general hospital; 100 students; 40-hour week; preparation for clinical field, a B.S. Degree or working toward a degree; salary open; liberal personnel policies. Apply, Director of Nurses, Middlesex Memorial Hospital, Middletown, Connecticut.

SUPERVISOR—Registered nurse; degree not necessary; responsibility of medical and surgical patient areas; supervision of graduate nurses and auxiliary personnel; salary dependent upon experience and ability; living accommodations available; 40-hour week, paid benefits. Write Personnel Office, The Jewish Hospital, Cincinnati 29, Ohio.

SUPERVISOR—Obstetrical; for a 36-bed unit; administrative and teaching responsibilities; 40-hour week; pleasant cooperative staff; forty-five minutes from New York City in a residential community; salary open; advance preparation required. Apply, MO 63, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11.

SUPERVISORS—Operating room supervisor and Assistant supervisor; salary open; complete maintenance if desired. Shriners' Hospital for Crippled Children, Philadelphia 15, Pennsylvania. MA 4-0700.

SUPERVISOR AND INSTRUCTOR—Operating room supervisor and clinical instructor for modern 250-bed hospital and school of nursing, 70 miles from New York City; fully approved; forty-hour week; four weeks paid vacation; sick time; hospital care; complete maintenance at $45 per month; salary $305 per month. Apply, Director of Nursing, Vassar Brothers Hospital, Poughkeepsie, New York.

classified advertising

POSITIONS OPEN

The Medical Bureau

M. BURNEICE LARSON—DIRECTOR

PALMOLIVE BUILDING CHICAGO

ADMINISTRATORS—(a) General hospital; fairly large size, currently under construction; competent organizer required; Pacific coast; minimum, $12,000. (b) General hospital to be completed soon; will open with 150 beds, 300 by end of 1954; residential town, short distance from several large cities; east. (c) General 300-bed hospital, relatively new; university trained man with considerable experience required; California. (d) Community hospital, 325 beds; town, 60,000 near university center; midwest. (e) To direct two hospitals which have recently merged, to be replaced by new hospital, 225 beds, within two years; serves community 50,000; residential town, near New York City. (f) General hospital, 125 beds, affiliated successful group; college town, south. (g) Small general hospital; expansion program; resort town near Chicago. (h) Assistant; qualified direct clinic; thousand patient visits daily; significant hospital experience, background in personnel, accounting desired; west. (i) Assistant; 500-bed general hospital; midwest. MH1-1

MEDICAL BUREAU—*Continued*

ADMINISTRATORS—NURSES. (a) Children's hospital; new building recently completed; 200 beds, facilities for expansion to 350; medical school affiliation; administrative training, considerable experience required. (b) New community general hospital, 45 beds; New England. MH1-2

ANESTHETISTS—(a) Three; new 210-bed private general hospital; staff of six anesthetists; residential town, midwest; $500-$600. (b) Association, 10-man group; college town, southwest. (c) Two; large general hospital; 40-hour week; $400-$500; New England. (d) Small hospital; resort town, Gulf Coast; $450, maintenance. (e) Fairly large hospital; $4713, quarters; Pacific Islands. (f) Association, group of anesthesiologists; California. MH1-3

DIETITIANS—(a) Chief; voluntary general hospital, 450 beds; attractive location; east; minimum $5000. (b) Assistant and therapeutic dietitians; 350-bed hospital affiliated with one of the country's leading private practice clinics; staff of 75 board specialists, 125 residents; large city, university medical center. (c) Chief and assistants; new hospital, 400 beds, affiliated university medical school; west. (d) To direct food service in cafeteria and restaurant of new hospital affiliated university group; west. (e) Chief; general hospital, 500 beds; new department university medical center; midwest; minimum, $5000. MH1-4

DIRECTORS OF NURSES—(a) Teaching hospital, 700 beds; one of country's leading schools of nursing; 300 students; facilities of the best; new nurses' residence; metropolitan area of East. (b) Voluntary general hospital, 500 beds; teaching affiliations; 200 students; five-year course; university center, midwest. (c) General 475-bed hospital, 170 students; all departments well staffed; interesting city outside continental United States; although tropical country, mild pleasant climate. (d) Voluntary general hospital; 265 beds, 90 students; one particularly interested in students required; California. (e) Nursing service only; relatively new hospital, 100 beds; year-round resort town, 70,000; south. (f) Director of nursing service; new hospital, small size, for medical cases only; no chronic patients; California. (g) Nursing service; new 400-bed hospital; under American auspices; Asia. MH1-5

EXECUTIVE HOUSEKEEPER—One of country's leading teaching hospitals; east. MH1-6

EXECUTIVE PERSONNEL—(a) Personnel director; general 550-bed hospital; 900 employees; east. (b) Chief comptroller; voluntary general hospital, 400 beds; expansion program; $8500; New England. (c) Business manager; hospital group; accounting background, purchasing experience required; south. (d) Food production manager; one of country's leading teaching hospitals; outstanding opportunity. (e) Director of maintenance; college graduate in engineering; 600-bed hospital; university center, midwest; $6000. (f) Purchasing agent; university group; large city medical center; east. MH1-7

(Continued on page 197)

classified advertising

POSITIONS OPEN

MEDICAL BUREAU—*Continued*

FACULTY POSTS—(a) Chairman, university nursing education department currently being instituted; qualified faculty in sciences, humanities, general education will contribute to program; up to $9000. (b) Assistant professors in neuropsychiatric, obstetrical, medical, surgical nursing; four-year program; leading university. (c) Educational director; fairly large general hospital; 200 students; interesting city, outside United States; mild climate. (d) Head, university department public health nursing; rank; assistant professor; minimum $6000. (e) Instructors in operating room, obstetrics, pediatrics, nursing arts; faculty appointments at university level; Pacific coast. (f) Nursing arts and clinical; voluntary general hospital, 200 beds; residential town, New Jersey; near New York City. MH1-8

HOSPITAL SECRETARY—To head department, 450-bed hospital; east. MH1-9

MEDICAL RECORD LIBRARIANS—(a) Chief; fairly large hospital, one of leading in California; capable organizer required. (b) To succeed chief of department, 450 beds; retiring after tenure 27 years; university town, east. (c) Chief; large teaching hospital; faculty rank; $5400-$6000; midwest. (d) Teaching hospital; New England; minimum $5000, if experienced in larger hospital. MH1-10

MEDICAL BUREAU—*Continued*

NON-INSTITUTIONAL—(a) Research assistant; medical school research department; training provided; midwest. (b) Chief nurse, 26-man group; east. (c) Courier nurses; transcontinental. (d) Student health; co-educational college; west. (e) Industrial nurse consultant; leading insurance company; some travel. MH1-11

SUPERVISORS—(a) Operating room and central sterilizing room; new 400-bed hospital; under American auspices; Asia; $5000. (b) Evening, obstetrical, psychiatric, pediatric and operating room supervisors; teaching hospital; attractive location; south; $4000-$5000. (c) Pediatric; 40-bed department; 300-bed hospital; collegiate program; Pacific coast. (d) Thoracic surgery; new department; 400-bed hospital; affiliated university, educational opportunity; east. (e) Pediatric; fairly large hospital; California; $300-$375. (f) Obstetrical and evening; general 275-bed hospital; residential town near two university centers; east. (g) Chief, operating room; new 350-bed hospital; affiliated important clinic; college town, east; minimum $5000. (h) Medical; new unit, university group; midwest; $360-$495. MH1-12

SURGICAL AND STAFF—(a) Surgical and staff; fairly large hospital; Florida. (b) Hospital, foreign operations, American company; $350, living allowance, $220. (c) Surgical; 18-man clinic; south. (d) Surgical; Costa Rica. MH1-13

MEDICAL BUREAU—*Continued*

TECHNICIANS—(a) Chief technician; 400-bed general hospital; M.S. preferred; college town. (b) Chief x-ray technician; should be qualified supervise staff of 12, conduct in-service training program; large teaching hospital. (c) Chief physical therapy technician; 450-bed hospital; university center. MH1-14

SHAY MEDICAL AGENCY
Blanche L. Shay, Director
55 East Washington Street
Chicago 2, Illinois

ADMINISTRATORS—(a) East; 250-bed hospital in process of expansion; fully approved, with an accredited school of nursing. (b) Middle west; modern 225-bed hospital located in city of 50,000; requires 5 to 10 years' experience as administrator in hospitals ranging from 100 to 150 beds in a city of comparable size. (c) Middle west; new 150-bed hospital, fully approved; located in progressive community of 25,000. (d) East; 275-bed hospital; requires at least 5 years' hospital administrative experience. (e) South; 100-bed hospital; new, modern in all respects; located in lovely southern community of 25,000. (f) Southeast; heart of winter resort area; 160-bed hospital.

(Continued on page 198)

classified advertising

POSITIONS OPEN

SHAY—*Continued*

DIRECTORS OF NURSES—(a) South: large hospital, fully approved, accredited school; all departments well staffed; $6000 to $7200. (b) Middle west: 250-bed general hospital; fully approved; 90 students in nursing school; B.S. Degree plus ten years' experience in supervising capacity; $6000 minimum. (c) Southeast: 70-bed hospital in winter resort city; permanent; affiliated with university. (d) Middle west: 200-bed hospital; not too far from Chicago; B.S. Degree, minimum; $6500. (e) East: 100-bed hospital in city of 40,000; fully approved; no nursing school; good salary plus complete maintenance including a lovely private apartment. (f) East: 130-bed hospital ideally located in suburban district close to New York City; living-in optional; attractive nurses' residence; $6000 minimum to start. (g) East: 100-bed hospital located in picturesque resort area; excellent educational and cultural facilities; $5000 minimum plus maintenance to start.

DIETITIANS—(a) Therapeutic: middle west; 200-bed hospital affiliated with local university; $4800. (b) Chief: east; 210-bed hospital in city of 50,000; 28 employees in department; fully approved; no nursing school; $5000 minimum. (c) Therapeutic: middle west; 180-bed hospital in city of 50,000; fully approved; accredited nursing school; $4200. (d) Chief; east; large tuberculosis sanitarium; excellent

SHAY—*Continued*

facilities and a well trained staff; $6000. (e) Chief; middle west; 300-bed hospital in city of 50,000; 60 employees in department; $5400 minimum to start. (f) Chief; Pacific Northwest; large hospital, fully approved, with an accredited nursing school; $6000 minimum to start. (g) Chief; south; new modern hospital located in lovely southern city of about 35,000; 40 employees in department; $5400 to start.

EXECUTIVE HOUSEKEEPERS—(a) South: large hospital, fully approved; staff of 6 assistant housekeepers, 30 maids, 26 porters; affiliated with university; opportunity to further education at no cost; $4500 minimum to start. (b) Middle west; 225-bed modern hospital; 14 employees in department; located in town of 10,000 close to Chicago; $4200. (c) Southeast; 230-bed general hospital with complete, modern facilities, located in large city; there are approximately 60 employees in the department; $5400. (d) South; 300-bed general hospital in beautiful resort area; ideal modern facilities; excellent educational and recreational facilities.

PHARMACISTS (a) Middle west; 200-bed hospital in city of 50,000; 4 employees in department; $400 minimum. (b) East; 300-bed hospital, fully approved; located not too far from New York City; Department newly organized and will have 5 employees in addition to chief; $5000. (c) South; 275-bed general hospital, fully approved; located in progressive city of 40,000; excellent facilities, both

SHAY—*Continued*

educational and recreational; $400. (d) Southwest; 80-bed general hospital, approved; located in pleasant small town in midst of winter resort area; $425.

ADMINISTRATORS—(a) Voluntary general hospital, 300 beds; newly opened last year; finest facilities; cooperative board; excellent staff; college town 150,000; southwest. (b) Medical; voluntary general hospital, 300 beds; excellent teaching program; prefer one trained in medicine; large city; northeast. (c) Lay; fully approved voluntary general hospital, 300 beds; finest facilities; cooperative board; attractively situated in pleasant town 30,000; half-hour to New York City. (d) Medical; direct program philanthropic organization; broad program improving quality hospital care; medical center and large group affiliated hospitals; opportunity faculty post. (e) Lay; fully approved general hospital, 240 beds; 2 million dollar expansion program; mid-Atlantic coast town 100,000. (f) Lay; to succeed director retiring after long tenure; voluntary general hospital, 375 beds, expanding to 500

(Continued on page 199)

classified advertising

POSITIONS OPEN

WOODWARD—*Continued*

beds; metropolis. (g) New hospital, 250 beds, opening soon; outstanding facilities; California. (h) Assistant director; specialty hospital, 200 beds; affiliated important university medical school; east. (i) Voluntary general hospital, 250 beds; east. (j) Assistant; experienced in public relations; voluntary general hospital, 200 beds; east. (k) Voluntary general hospital, 300 beds; midwest. (l) General hospital, 100 beds; university city; midwest. (m) Voluntary general hospital, 220 beds; east. (n) Assistant; voluntary general hospital, 175 beds; near Detroit. (o) Medical; psychiatric institution; psychiatric training unnecessary; $12,000; home; complete maintenance.

EXECUTIVE PERSONNEL—(a) Chief comptroller; general voluntary hospital, 400 beds; medical school affiliation; expansion program; $8500; New England. (b) Accountant—office manager; group 12 distinguished specialists; should be familiar group-practice accounting procedures; west coast. (c) Personnel director; voluntary general hospital, 500 beds; very progressive town 150,000; about $6000; midwest. (d) Personnel director; voluntary general hospital 600 beds; prefer experienced but not necessary; large city, university medical center; east.

MEDICAL PERSONNEL EXCHANGE
Nellie A. Gealt, R.N., Director
311 Land Title Building
Philadelphia 10, Pennsylvania

ANESTHETIST—140-bed hospital, Philadelphia area; $400 plus maintenance.

DIRECTORS OF NURSES—(a) Large hospital, east; requires top-flight young person; traveling expenses paid for interview. (b) 130-bed home and hospital; degree not required; salary open.

EXECUTIVE HOUSEKEEPERS—(a) Large hospital, New York City; 40-hour week; salary open. (b) 225-bed hospital, western Pennsylvania; $4200.

MEDICAL RECORD LIBRARIAN—Head; large hospital; 40-hour week; $3900 plus maintenance.

PHYSICIANS—(a) OB-gynecologist. (b) General practitioner; 11-man group; good hospital connections; minimum starting salary $12,000; good opportunity for advancement. (c) Industrial; good company, eastern Pennsylvania; starting salary $8500; 40-hour week.

OPERATING ROOM SUPERVISOR—160-bed hospital; graduate staff; university town; $315 plus maintenance.

No charge for registration

(Continued on page 200)

INTERSTATE MEDICAL PERSONNEL BUREAU
Miss Elsie Dey, Director
332 Bulkley Building
Cleveland, Ohio

ASSISTANT ADMINISTRATORS—(a) 250-bed hospital, Massachusetts. (b) New Jersey; 300 beds.

BUSINESS MANAGERS—(a) 600-bed hospital, university city. (b) Comptroller; 150-bed southern hospital.

DIETITIANS—Administrative; to $450.

DIRECTORS OF NURSING SERVICE—(a) 200-bed hospital, new modern building; eastern city. (b) 175-bed Ohio hospital. (c) 200-bed hospital, Texas. (d) 215-bed hospital, Virginia.

EXECUTIVE HOUSEKEEPERS—(a) 300-bed hospital, New York. (b) 200-bed new hospital, central states. (c) 300-bed Wisconsin hospital.

RECORD LIBRARIAN—200-bed eastern hospital.

PERSONNEL DIRECTORS—(a) 500-bed hospital, Michigan; $5500. (b) 275-bed Ohio hospital; open February.

classified advertising

POSITIONS OPEN

INTERSTATE—*Continued*

REGISTERED NURSE SUPERINTENDENTS —(a) New hospital under construction, midwest; attractive college town. (b) Modern orthopedic hospital; west.

SUPERVISORS — (a) Night; 150-bed Ohio hospital; $350. (b) Operating room supervisors; to $375.

BUSINESS AND MEDICAL REGISTRY
(Agency)
Elsie Miller, Director
610 South Broadway, Room 1105
Los Angeles 14, California

DEAN—Western university school of nursing; interest and ability more important than wide experience.

DIRECTOR OF NURSES—Southern California city near ocean; long-established maternity hospital, 20 beds; new building increasing to 125 beds ready during 1954, converting to general hospital, including outpatient clinic; starting salary, $400, sharp increase with new building.

OPERATING ROOM NURSE Forty-bed well equipped, approved hospital; limited call, time made up; recreation facilities; $425 plus maintenance.

PLACEMENT BUREAUS

ZINSER PERSONNEL SERVICE

Anne V. Zinser, Director

Suite 1004—79 West Monroe Street

Chicago 3, Illinois

We have many good openings for Directors of Nurses, Instructors, Supervisors, Dietitians, Medical Technicians, Record Librarians and Staff Nurses. If you are looking for a position, please write us.

INDIANA MEDICAL BUREAU

212 Bankers Trust Bldg.

Indianapolis, Indiana

Opportunities in most areas for Administrators, Medical Directors, Anesthesiologists, Pathologists, Radiologists, Resident Physicians, Laboratory and X-Ray Technicians, Therapists, Medical Records Librarians, and all areas of supervisory hospital and medical personnel.

(Continued on page 202)

PLACEMENT BUREAUS

MARY A. JOHNSON ASSOCIATES
11 West 42 Street New York 36, N. Y.
Mary A. Johnson, Ph.D., Director

FINE SCREENING BRINGS BEST RESULTS

Our careful study of positions and applicants produces maximum efficiency in selection. Candidates know that their credentials are carefully evaluated to individual situations, and only those who qualify are recommended. Our proven method shields both employer and applicant from needless interviews. We do not advertise specific available positions. Since it is our policy to make every effort to select the best candidate for the position and the best job for the candidate, we prefer to keep our listings strictly confidential.

We do have many interesting openings for Administrators, Physicians, Anesthetists, Directors of Nurses, Dietitians, Medical Technicians, Therapists, and other supervisory personnel.

No registration fee

classified advertising

PLACEMENT BUREAUS

HOSPITAL PERSONNEL BUREAU
Charles J. Cotter, Director
(Licensed Employment Agent)
Professional Arts Bldg.
Hagerstown, Maryland
Telephones: Office—950; Res.—2885

Positions available, most areas, Administrators, Pathologists, Anesthetists, Pharmacists, Housekeepers, Technicians, Dietitians, Librarians, Directors of Nurses and all nursing positions. Send resumé, 10 snapshots, date available.

THE MEDICAL FIELD
EMPLOYMENT AGENCY
790 Broad Street — cor. Market
Newark 2, N.J.
MItchell 2-1940, 1941

A MEDICAL AGENCY specializing in placements for Industry, Pharmaceutical Houses, Doctors' Offices and Institutional help.

Eleanor M. Mangini, R.N.
Director

PLACEMENT BUREAUS

BROWN'S MEDICAL BUREAU (Agency)
7 East 42nd Street
New York City 17

If you are seeking a position or personnel—please write. Gladys Brown, Owner-Director. We Do Not Charge a Registration Fee.

CALIFORNIA AND WEST COAST
Complete Coverage
Hospitals—Clinics
Excellent Openings—Confidential Services

CONTINENTAL MEDICAL BUREAU, Agency
510 West 6th Street, Los Angeles 14

PACIFIC COAST MEDICAL BUREAU.
Agency
703 Market Street, San Francisco 3

FOR SALE

Nurses Registry and Employment agency. Established 1920. Located in Fresno, California. Complete protection to buyer re license, lease, advertising and telephone. Reason for selling: other business interests. Write, P. O. Box 561, Fresno, California. Price $5000 for quick sale.

FOR SALE

New and used hospital equipment bought and sold. Large stock on hand for the physician, hospital and laboratory. Write for what you want or have for sale.

HARRY D. WELLS
400 East 59th Street, New York City

NURSING AND MEDICINE
We have in stock every nursing or medical book published. Lowest prices with unexcelled service. Write Chicago Medical Book Company, Jackson and Honore Streets, Chicago 12, Illinois.

FOR SALE: Lead glass, eight panes, 32 x 36 inches, ¼ inch thick, $100 each. F.O.B. Write, MS 55, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11.

MISCELLANEOUS

HOSPITAL SALESMAN WANTED
Leading manufacturer of maintenance, Sanitary and Floor Treatment Chemicals offers 5-figure per annum strictly commission opportunity to experienced salesman. Write fully: BRAMCO, 820—65th Ave., Philadelphia 26, Pa.

LINE WANTED—WESTERN CANADA
Agent for "Polar Ware" wants one additional major line with $100,000 potential volume. Write: H. Douglas Latter, 388 Donald Street, Winnipeg, Manitoba, Canada.

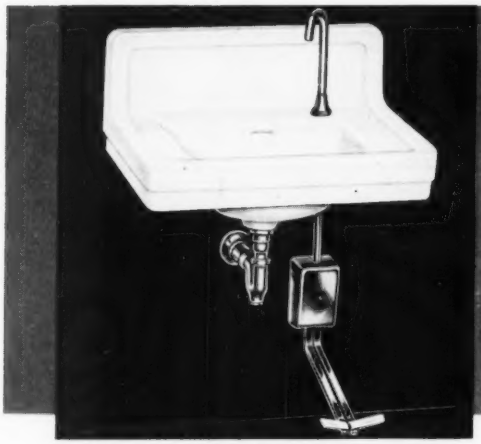
SCHOOLS—SPECIAL INSTRUCTION

The PROVIDENCE LYING-IN HOSPITAL offers to qualified graduate nurses a four months supplementary clinical course in Obstetrics. Full maintenance and stipend of $60 a month provided. For full information, apply to the Director of Nurses, Providence Lying-in Hospital, Providence 8, Rhode Island.

SCHOOL FOR LABORATORY TECHNICIANS—Duration of course, 1 year. Tuition, $100.00; approved by the American Medical Association. For further information, write the Director of Laboratories, Barnes Hospital, 600 S. Kingshighway, St. Louis, Mo.

CHILDREN'S HOSPITAL of Washington, D. C., offers a six months' advanced course in pediatric nursing. Classes begin (approximately) the first of April and October. Address inquiries to: Director of Nursing, Children's Hospital, 2125 13th St. N. W., Washington 9, D. C.

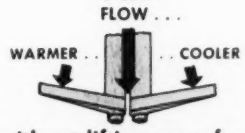
WOMAN'S HOSPITAL, Detroit, Michigan, offers a four months' clinical course in obstetric nursing to qualified professional nurses. Full maintenance and a monthly stipend of $100 allowed. Class enters March 2, 1954. For further information, apply Director of Nurses, 432 E. Hancock Avenue, Detroit 1, Michigan.



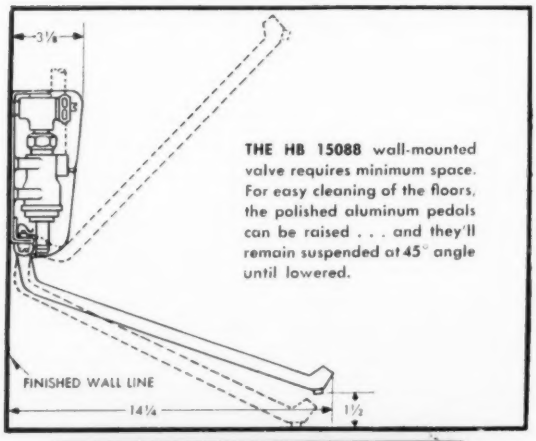
HF 12145 P vitreous china lavatory with HB 15088 pedal valve and type N tempered supply line. This valve is ideal for use with surgeons' scrub-up sinks and other lavatories, too.

Angled pedals permit one-foot control of water flow and water temperature

. . . with this new Double-Pedal Mixing Valve



without lifting your foot



THE HB 15088 wall-mounted valve requires minimum space. For easy cleaning of the floors, the polished aluminum pedals can be raised . . . and they'll remain suspended at 45° angle until lowered.

Angled pedals make this new wall-mounted, foot-operated valve more convenient to use. One foot controls both water flow and water temperature, leaving hands *completely* free.

With this new pedal design, the heel acts as a pivot. Light pressure on one pedal starts flow of hot water, pressure on the other a supply of cold water. An even down-pressure produces tepid water. You get maximum water flow with only 1½" pedal travel.

This new self-closing valve brings welcomed convenience to many fixtures. With a bedpan cleanser, for instance, it eliminates fussing with other valves. Water is controlled solely by the foot pedals. When pedals are released, water automatically shuts off . . . no pressure is left in the hose.

HF 13411 VP GLENCO TOILET is shown with HB 15334 foot valve bedpan cleanser assembly. Pedal valve can also be specified for other closets and clinic service sinks.

AMERICAN-Standard

American Radiator & Standard Sanitary Corporation, P. O. Box 1226, Pittsburgh 30, Penna.

Serving home and industry

AMERICAN-STANDARD • AMERICAN BLOWER • CHURCH SEATS & WALL TILE • DETROIT CONTROLS • KEWANEE BOILERS • ROSS EXCHANGERS • SUNBEAM AIR CONDITIONERS

LUDMAN Auto-Lok AUTOMATIC LOCKING PATENTED WINDOWS

THE TREND IS TO AWNING  WINDOWS

only LUDMAN Auto-Lok WINDOWS give performance like this!

HERE ARE JUST A FEW OF THE MANY HOSPITALS EQUIPPED WITH LUDMAN WINDOWS . . .

Barbour County Hospital
Eufaula, Alabama
Sealevel Community Hospital
Sealevel, North Carolina
Kingfisher Clinic
Kingfisher, Oklahoma
Mound Park Hospital
St. Petersburg, Florida
Keokuk County Hospital
Sigourney, Iowa
Rose Caplan Infirmary
Buffalo, New York
St. Agnes Hospital
Fond du Lac, Wisconsin
Hospital Dormitory Building, State Training School
Clinton, South Carolina
Good Samaritan Hospital
Dayton, Ohio
St. Francis Hospital Addition
Burlington, Iowa
Easley Hospital
Easley, South Carolina
St. Joseph's Hospital
Eureka, California
Community Memorial Hospital
South Hill, Virginia
Health Center
Monroe, Georgia
Morris County Welfare Home
Morris County, New Jersey
Southwestern Samaritan Hospital
Kalamazoo, Michigan
Valdosta Hospital
Valdosta, Georgia
Wyoming County Community Hospital
Warsaw, New York
Washington County Hospital
Chatham, Alabama
State TB Hospital
Salem, Oregon
Hancock Memorial Hospital
Britt, Iowa
Toledo Health Center
Toledo, Ohio
Nurses Building, Mercy Hospital
New Orleans, Louisiana
St. Joseph's Hospital
Wichita, Kansas
Nathan Bryan Whitfield Memorial Hospital
Demopolis, Alabama
Mainenides Hospital
Liberty, New York

And what performance! Ludman Auto-Lok Windows give you complete all-weather window ventilation control! They open wider! They close tighter . . . seal shut ten times tighter than generally accepted standards. Each vent *locks* automatically at *all four* corners when closed. They help air-conditioning and heating equipment to operate more efficiently. And because of their design Ludman Auto-Lok are the simplest, easiest operating windows of all . . . easiest to regulate for patients comfort. They never need adjustment . . . never wear . . . will give a life-time of trouble-free performance.

LUDMAN Auto-Lok AUTOMATIC LOCKING SPECIAL HOSPITAL WINDOWS

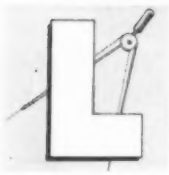
Burlington Protestant Hospital, Burlington, Iowa
Morgan-Gelatt & Associates, Architects

Busy nurses appreciate Ludman Special Hospital Windows because they operate so easily, so smoothly—with only a finger-touch!

LUDMAN *Corporation*

Box 4541, Dept. MH-1, Miami, Florida

Hospital Officials! Architects! Write for descriptive literature



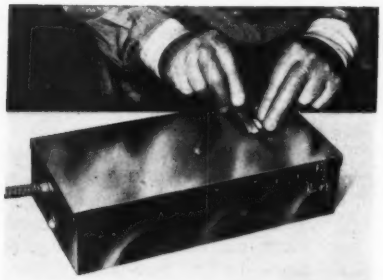
LUDMAN LEADS THE WORLD IN WINDOW ENGINEERING

What's New for Hospitals

JANUARY 1954 Edited by BESSIE COVERT

TO HELP YOU get more information quickly on the new products described in this section, we have provided the postage paid card opposite page 228. Just circle the key numbers on the card which correspond with the numbers at the close of each descriptive item in which you are interested. The MODERN HOSPITAL will send your requests to the manufacturers. If you wish other product information, just write us and we shall make every effort to supply it.

Carrying Case for Sterilizing Bone Saw



The Stryker Bone Saw Sterilizing Case serves not only for carrying the bone saw and blades but as a sterilizing case. Saw and blades stay together in the case during storage, sterilization and use on the operating table. The saw is easily removed to be used for a portable saw. When fastened in the case with the lid closed the bone saw serves as a table saw for fashioning autogenous grafts or bone bank bone. It can also be used in preparing cadaver bone for bone banks.

The case is made of stainless steel. It is small and compact and protects the blades at all times. Following use the saw and blades are cleaned and returned to the case where they may be stored and sterilized as a unit ready for immediate use. **Orthopedic Frame Co., Dept. MH, 420 Alcott St., Kalamazoo, Mich. (Key No. 1)**

Automatic Printing Calculator Facilitates Figure Work

Fast, easy and accurate figure work is assured with the new Model 99 Automatic Printing Calculator. The high speed mechanism automatically calculates, proves and prints on tape any problem involving fully automatic multiplication, division, addition or subtraction. Even with complex factors, high operator output is obtained with the new machine.

Features of the ten-key, touch-method keyboard machine include the Simpla-Tape, Automatic Clearance, Constant Multiplication and Total Control. Simpla-Tape provides proof of figure work accuracy, eliminating superfluous steps and increasing the readability of the tape for record purposes. The calculator clears automatically at the end of each problem, but it can retain a multiplicand indefinitely if desired. This is the basis of the Constant Multiplication. The Total Control feature facilitates accumulative multiplication. **Remington Rand Inc., Dept. MH, 315 Fourth Ave., New York 10. (Key No. 2)**

Automatic Bedpan Washer Assures Decontamination

The new Cyclo-Flush is an automatically operated unit which assures complete cleansing and decontamination of bedpans and urinals. The door is opened

by foot operation, the bedpan or urinal is placed in the locking arms of the door which closes when the foot pedal is released, and the automatic operation is started by depressing a button with the forearm. The nurse or attendant need not touch the unit with her hands.

A powerful jet of cold water washes the bedpan for 25 seconds after which the chamber is flooded with live steam for 30 seconds, completely sanitizing the utensil. The automatic operation eliminates the possibility of any shortcut in the technic and saves nurses' time. **American Sterilizer Company, Dept. MH, Erie, Pa. (Key No. 3)**

(Continued on page 208)

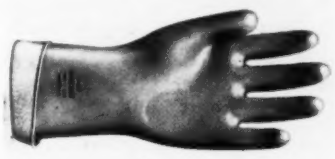
Manifolds Ensure Continuous Gas Supply

The new line of Oxweld stationary manifolds ensures a continuous flow of therapy gases at controlled pressures. Use of the new manifolds and feed lines permits centralization of gas supply using a minimum of floor space and reducing labor and maintenance costs. The new line offers a wide choice of both single-regulator and dual-regulator manifolds.

In the dual-regulator series the reserve bank of cylinders picks up the gas load automatically when the usable supply in the operating bank of cylinders is exhausted. Each cylinder bank is controlled by its own pressure regulator, high pressure inlet control valve, low pressure valve and a relief valve that is re-seated. Flexibility of design permits adding individual extensions for any number of cylinders in single or double rows. **Linde Air Products Co., Dept. MH, 30 East 42nd St., New York 17. (Key No. 4)**

Medical Utility Glove For Non-Surgical Use

A new liquid-tight glove has been developed for non-surgical hospital and autopsy use. The U-35 Medical Utility Glove is designed for long, hard service. It is made of specially processed DuPont neoprene which resists oils, acids, caustics, grease and detergents. The glove has a soft flock lining and this, together with the short curved fingers and extra roominess across knuckles and palm, provides more hand comfort for the wearer. The U-35 is gray with yellow flock lining and is available in small, medium and large sizes. **The Pioneer Rubber Company, Dept. MH, Willard, Ohio. (Key No. 5)**



What's New . . .

Medicine Cart With Interchangeable Trays

The new Tomac Medicine Cart can be adapted to any specific requirements. Removable, interchangeable trays result in a flexible unit which permits one nurse to administer all medications quickly on one trip. The cart is of all stainless steel construction and has two full width shelves welded to 1 inch corner posts and a drawer 2⅜ inches deep. The three removable, interchangeable gray plastic trays are fully equipped and may be washed in hot water and cold sterilizer. Without the trays, the cart can be used for general utility in transporting supplies.

Included in the complete unit are 500 each of 10 different colored medicine cards, 36 one ounce medicine glasses, stainless steel case for syringes, stainless steel forceps jar, two stainless steel dressing jars, stainless steel waste jar and 12 five ounce fruit juice glasses. **American Hospital Supply Corp., Dept. MH, Evanston, Ill. (Key No. 6)**

Explosion-Proof Switch Has Adjustable Cover

The new Appleton EHS series explosion-proof switch is a versatile economical unit. Because of the adjustable cover features it is particularly suited to modernization. It can be quickly installed in walls of varying plaster or tile thickness and is so designed that it will compensate for variations up to five degrees off level. The new switches are designed for use in any hazardous area in the hospital. **Appleton Electric Co., Dept. MH, 1743 Wellington Ave., Chicago 13. (Key No. 7)**

Effective Cleaner for Instruments

Developed by a manufacturer of surgical instruments, the Weck Cleaner is effective for use on surgical instruments, laboratory glassware and rubber equipment. It is the result of years of research, is free from caustic and is safe to use. It is designed to remove clotted blood and other contamination rapidly as it wets and penetrates deeply. It emulsifies oils and cleans effectively even in hardest water. Weck Cleaner dissolves rapidly in warm water, does not produce foam to interfere with mechanical washing and inhibits corrosion on surgical instruments. **Edward Weck and Co., Inc., Dept. MH, 135 Johnson St., Brooklyn 1, New York. (Key No. 8)**

Thermo-Mist For Moist-Air Therapy

An advance design of the Moist-Air Therapy Unit is offered in the new Ideal Thermo-Mist. The unit consists of an electric welded stainless steel table 6½ feet long, 37 inches wide and 54 inches high. The stainless steel treatment hood, fitted with moisture-proof, plastic curtains, is an integral part of the unit. The hood and recirculating unit are kept on the 23 inch hinged stainless steel shelf when not in use.

Also part of the unit is a foam latex mattress with moisture-proof covering.

The exact, desired temperature of moist air within the treatment hood is assured through the automatic push-button controls for heat and timer. A dial thermometer is standard equipment. The tracks on which hood and operating unit move are integral parts of the stainless steel table. The operating unit can be placed on either side of the table. **The Swartzbaugh Mfg. Co., Dept. MH, 1336 W. Bancroft St., Toledo 6, Ohio (Key No. 9)**

Plastic Rectal Tube Is Easily Cleaned

The Pharmaseal K-40 is a plastic rectal tube which is easy to clean, is transparent and can be visually checked for cleanliness. It is made of smooth, non-irritating plastic with long life, which retains firmness after repeated use. The smooth, molded tip and eye are designed for patient comfort and flexible, plastic connector fits standard accessory equipment. **Pharmaseal Laboratories, Dept. MH, Glendale 1, Calif. (Key No. 10)**

Bedside Drainage With Disposable Tubes

A new 9/32 inch Bardic Disposable Plastic Bed Side Drainage Tube has been developed by Sterilon. This makes two sizes of disposable tubes available in the line, one for normal drainage and the new one for use where drainage may be retarded by blood clots. The heavy wall thickness of Bardic Tubes prevents possibility of kinking. The tubes are five feet long, each with an adaptor to connect one end of the tube to an indwelling catheter. **Sterilon Corp., Dept. MH, 500 Northland Ave., Buffalo 11, N.Y. (Key No. 11)**

Automatic Valve Control For Fluid Level

A new valve has been developed for the automatic control of the level of water or irrigating fluid in a percolator or similar reservoir. With this device it is not necessary to hand fill the water percolator during cystoscopy, resection or other procedures requiring an irrigating medium. Known as the Weyrauch Float Valve the device fits on top of most standard glass percolators. Three adjustable screw lugs permit attachment to percolators having maximum diameter of 6.75 to 7.25 inches. **American Cystoscope Makers, Inc., Dept. MH., 1241 Lafayette Ave., New York 59. (Key No. 12)**

Folding Wheel Chair Has Extra Support

A dual cross brace support is incorporated into the new Colson Folding Wheel Chair to give it extra stability. The new Model 4349 chair folds to only 9½ inches wide, requiring minimum storage space and making it fit easily into an automobile. The new flared design of the chair arms permits greater seat width for maximum comfort. There is an adjustable foot rest which has a strong, positive locking device. New 8 inch swivel ball bearing

wheels in front make steering easy and afford maximum maneuverability. **The Colson Company, Dept. MH, Elyria, Ohio. (Key No. 13)**

(Continued on page 212)

Even better than ROAST TURKEY? How can it be?

No, nothing **can** be better eating than an expertly cooked, oven-roasted, tender, young turkey — for holidays or any day. That's one reason **turkey consumption has grown faster since the war than any other meat!**

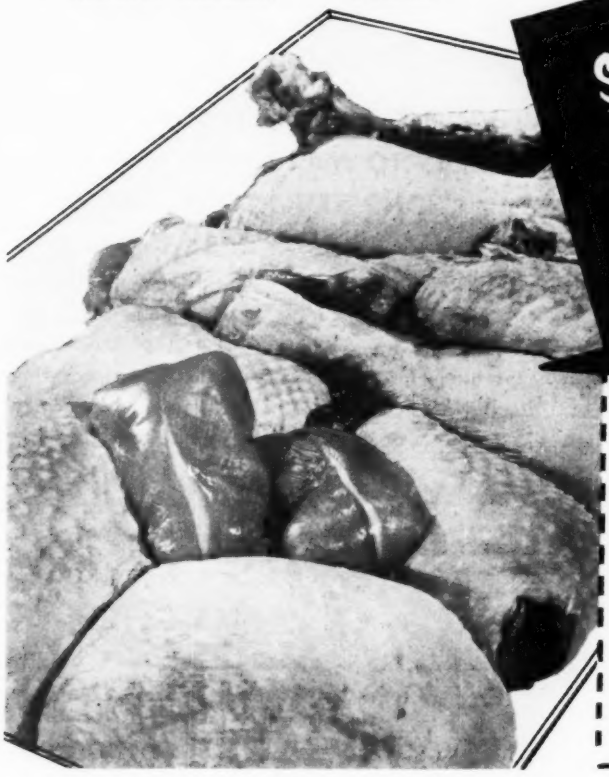
But for the institution — the restaurant, hotel, hospital, school lunchroom — there may be . . . **there is** . . . a more economical way to cook turkeys for many uses without sacrificing either taste or appearance than by oven-roasting them. At least some folks you know and respect think so.

THIS NEW METHOD OF TURKEY COOKERY, developed and endorsed by National Turkey Federation, National Restaurant Association, and Poultry and Egg National Board, can be used by you and to your advantage in the making of virtually every type of turkey dish — roast turkey dinners, hot and cold sandwiches, salads, creamed and fricassee dishes, fried and broiled turkey pieces, and "made" dishes of all kinds.

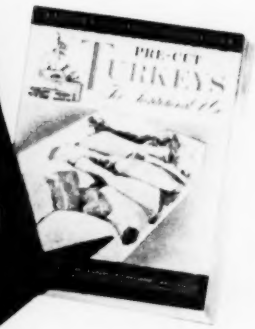
This method — especially for those who can buy pre-fab turkey now being packed in some areas for this purpose — **saves time in pre-cooking preparation ✲ ✲ ✲ saves stove and storage space ✲ ✲ ✲ cuts cooking and carving costs ✲ ✲ ✲ reduces shrinkage. It also gives better portion control and higher yield of cooked meat.**

If you want to know all about **The New Method of Turkey Cookery** and where you can buy the new Pre-Fab Institutional Pack — an entire Grade A large tom turkey in pre-fabricated form in each compact container; a completely prepared turkey that is all ready for popping into the pan, use the coupon.

NATIONAL TURKEY FEDERATION
MOUNT MORRIS, ILLINOIS



SEND FOR
FREE booklet and name and address of your poultry supplier



NATIONAL TURKEY FEDERATION

Mount Morris, Illinois
Please send me FREE the following.

☐ **Name of turkey processor nearest me who can supply me with "Ready-Pack" turkey for institutional use.**

☐ **Illustrated booklet on how to cook and prepare pre-cut turkey.**
Distribution of booklets limited to continental United States

Name .....

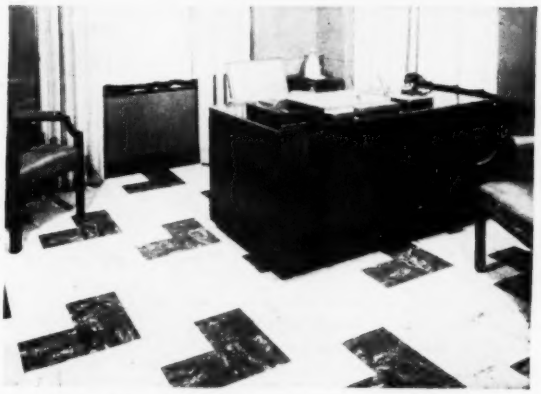
Institution .....

Address .....

City and State .....

Johns-Manville *TERRAFLEX* tile,

made of vinyl plastics and asbestos, offers advantages never before combined in one type of flooring



COLORS ARE CLEARER
The vivid colors of Johns-Manville Terraflex Flooring have a clarity and warmth that add beauty to any interior—keep their *first day newness* for a lifetime. The wide range of marbleized colors in harmonious and contrasting shades offers unlimited freedom of design.

EASIER TO MAINTAIN
Terraflex is resistant to grease and oil, alkaline moisture and mild acid solutions. It is easy to clean and even caustic soaps which permanently damage other types of resilient floorings will not affect Terraflex—it cannot "wash out." Many different decorative inserts are available to add interest and individuality to floor design. Knife-fork and teakettle inserts are shown above. Moisture-resistant, Terraflex is ideal for laying over radiant-heated concrete floors in direct contact with the ground.

WILL LAST A LIFETIME
Although Terraflex is extremely resilient, it will outwear other types of decorative floor coverings two to one. With its superior flexibility it conforms to uneven surfaces and absorbs the normal floor play. It does not crack, curl, become loose, or brittle, or shrink around the edges. It does not become fuzzy or scratch or lose its sheen from constant wear.

FOR THE BEST there is in flooring—look to Johns-Manville Terraflex.

Send for a free brochure showing the full color line of Johns-Manville Terraflex and Asphalt Tile. Write Johns-Manville, Box 60, New York 16, N. Y.

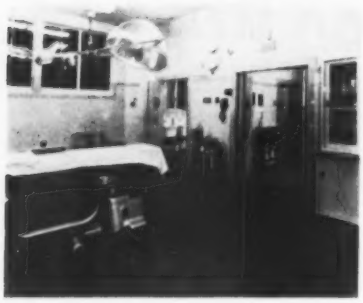
JOHNS MANVILLE JM PRODUCTS

Johns-Manville

TERRAFLEX AND ASPHALT TILE FLOORING

What's New . . .

Conduct-O-Tile Flooring For Hazardous Areas



A new resistance-controlled ceramic flooring material has been introduced to offset the gas explosion hazards in the surgery. Known as Conduct-O-Tile, the new flooring contains small black ceramic tiles especially developed to ground electrical charges safely. It is recommended by the manufacturer for floors in operating rooms, delivery rooms, the corridors outside these rooms, and areas where anesthetics are stored. The flooring was developed to conform to the recommendations of the National Fire Protection Association for maximum allowable resistance for control and dissipation of static electricity.

The new tile is manufactured in 1⅛ inch squares. It is compounded of a vitreous carbon mixture and is impervious to strong cleaning agents, anesthetics and chemicals, is waterproof, fireproof and stainproof. The color is permanent, maintenance costs are at a minimum when it is used, and there is no carbon dust. The new floors combine suitable colors and patterns with the safety feature. **American-Olean Tile Co., Dept. MH, Lansdale, Pa. (Key No. 14)**

Insulated Counter Model Electric Steam Cooker

Frequent fresh preparation of cooked foods is possible with the new Model ST-E Steam-It. It is a new electric, automatic, insulated counter model pressure cooker which combines maximum cooking speed with minimum power consumption. Cooking is done in standard cafeteria pans, perforated or solid, depending upon the food being prepared. The clock is set at the proper cooking time when the food is placed in the cooking compartment and the automatic operation turns off the heating elements and allows the steam pressure to escape.

The unit is equipped with standard safety devices and features an inside self-sealing door which cannot be opened when there is any steam pressure. The unit is compact and easy to install. It is designed for counter installation but a stainless steel stand can be furnished if required. **Market Forge Co., Dept. MH, Everett, Mass. (Key No. 15)**

Rubber Runner has Plastic Surface

Frestep is the name of a new, low cost, plastic-surfaced sponge rubber aisle runner. The resilient material is easily cleaned and gives added comfort even where traffic flow is heavy. The new vinyl plastic cover is of an improved long-wearing type designed for years of service. The runner is manufactured in 36 inch width in 25 yard rolls. It is available in dark green, brown, red and gray. **Fremont Rubber Co., Dept. MH, Fremont, Ohio. (Key No. 16)**

Bench Type Mixer Handles 20 Quarts

The Univex Model 1220 Food Mixer features a planetary action principle of operation. The mixing unit revolves on an axis as it spins, assuring a clean complete mix of all ingredients. It has an automatic timer and triple-duty control switch for positive control of mixing time. A variable speed control gives efficient operation to mixes of differing consistencies.

The low cost, efficient, multiple purpose mixer has a capacity of 20 quarts. It has power outlets which can be utilized for meat chopping, shredding, cutting and other attachments. It is a bench type mixer constructed of heavy duty welded steel, Duco finished. It is designed with a minimum of parts so that maintenance cost is low. The mixer is also available with a heavy steel stand equipped with legs to raise it off the floor for easy cleaning underneath. **Universal Industries, Dept. MH, 360 Mystic Ave., Somerville, Mass. (Key No. 17)**

Tray Rack Eliminates Hand Washing

Hand washing of plastic, aluminum and stainless steel trays can be eliminated with the new special tray-washing rack recently introduced. It is available for use in every model of dishwashing machine. The rack features individual tilted compartments which protect the trays and permit thorough and sanitary washing. The rack is sturdily constructed with each cross wire crimped around the inner shell and an angle iron frame around the bottom. **Metropolitan Wire Goods Corp., Dept. MH, 70 Washington St., Brooklyn 1, N. Y. (Key No. 18)**

(Continued on page 214)

Air Cleaner Has Electrostatic Filter

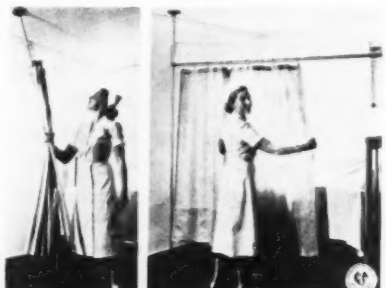
The Dustronic is an improved electrostatic filter air cleaner which collects all kinds of airborne particles and fluids, leaving the room air clean and sterile. It greatly reduces the bacteria and fungus counts, removes dust and pollen and collects fluids and mists. All airborne allergenic particles are removed by a specially treated mechanical aluminum filter. It clears the air so that a room can be occupied by a patient without subjecting him to allergic reactions.

The Dustronic is a self-contained unit in an attractive cabinet. The perforated top distributes the air in all directions without drafts and a large two-speed fan pulls the air in through the bottom through a patented filter. The device is odorless in operation and can be plugged into any light socket. **Radex Corporation, Dept. MH, 2076 Elston Ave., Chicago 14. (Key No. 19)**

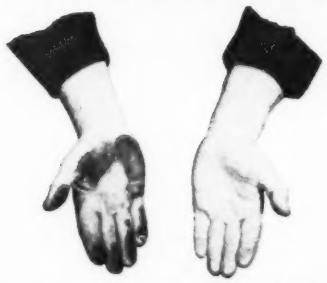
Lightweight Cubicle Screen Anchors Firmly

A new type of light weight cubicle screen has been developed. It anchors to the supporting Polecat which is adjusted to the ceiling height of the room. The rigid six foot screen can be adjusted with one hand by raising the curtain boom, attaching the stainless steel halyard and pulling the curtain across the boom. The height of the curtain can be easily adjusted as desired.

The anchor pole is made of sturdy anodized aluminum that does not corrode and is light in weight. Halyard and curtain hooks are of stainless steel and the curtain, which is six feet long and five feet high, is of white Sanforized 160 count cloth. The telescoping supporting pole fits any ceiling up to 10 feet 8 inches but special poles can be made up for higher ceilings. The ceiling pad cannot mark the ceiling and the screen folds back against the wall out of the way when not in use, or can be stored in a minimum of space. The screen cannot be knocked over and is not in the way for cleaning the floor. **Polecats, Incorporated, Dept. MH, Lyme, Conn. (Key No. 20)**



. . . eliminate dust with WESTONE!



Dramatic proof of ANTISEPTIC WESTONE'S effectiveness. The hand at left was rubbed across an ordinary untreated section of floor. The hand at right was rubbed over a section which had been treated with dust-controlling ANTISEPTIC WESTONE.

Sweeping only rearranges dust. As a matter of fact, sweeping and floor traffic are the main dust spreaders—not open doors and windows as you might think. And dust is damaging. It spreads many harmful disease bacteria that often cause absenteeism. It affects precision apparatus and delicate finished products. Makes store merchandise, office and institutional floors unsightly.

ANTISEPTIC WESTONE CONTROLS DUST. Loosens and picks it up from floors, bins, shelves, furniture. Seals floor surfaces. Improves their appearance. Holds down subsequent dust so traffic can't raise it. Its antiseptic properties inhibit growth of bacteria.

ANTISEPTIC WESTONE is economical. It works as fast as a man can walk. One man can do the work of three in maintaining floors. And it goes a long way. One gallon covers 4,000 square feet. Interested? Check the coupon.

WEST DISINFECTING Company

42-16 West Street, Long Island City 1, N. Y.

WANT DETAILS?

Tear out this coupon and mail with your letterhead

Dept. 12

I'm interested in:

☐ A FREE leaflet on WESTONE.

☐ A talk with a West expert about my special floor problems. No sales pitch. No obligation. Just discussion and a demonstration if I want it.

What's New . . .

Automatic Apparatus For Cough Expulsion

A simple, completely automatic apparatus for mechanical cough expulsion, to eliminate retained bronchial secretions, is offered in the O.E.M. Portable Cofflator. It is equipped with pressure, volume and time interval control and provides intermittent positive and negative pressure-breathing. It was developed by Dr. Alvan L. Barach, Dr. Gustave J. Beck, William H. Smith and associates at the Department of Medicine, Columbia University College of Physicians and Surgeons and the Presbyterian Hospital, New York. It is designed for use in the treatment of atelectasis, emphysema, poliomyelitis, asthma and bonchiectasis where there is retention of bronchial secretions. Because it is portable, the instrument can be used at the bedside, in office or treatment room and in the patient's home. **O.E.M. Corporation, Dept. MH, East Norwalk, Conn. (Key No. 21)**

Device for Continuous Tape Recording

A new sound recording and reproducing device is now being made available for general use. It was developed after years of research and used for the past year at Naval air stations. It is an extremely light, compact continuous recording device which is able to record the exact time messages are received, the elapsed time between recordings, and allows fast place-finding without an audible search. The device is capable of delivering 24 and 48 hours of continuous, unattended high quality magnetic recording.

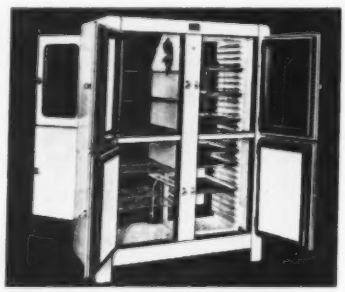
Safety controls built into the recorder include a buzzer which sounds in case of power failure, when the machine nears the end of the tape, or if the tape breaks. The instrument plays back recordings instantly when a playback switch is thrown. The device can be used wherever an unmanned uninterrupted listening device is required for long communications, as in recording meetings, surgical procedures, classroom sessions and similar material. The tape can be erased by a bulk demagnetizer in 20 seconds and reused indefinitely. **The SoundScriber Corporation, Dept. MH, 146 Munson St., New Haven 4, Conn. (Key No. 22)**

Maximum Suction with Vacuum Hand Nozzle

Dust is collected directly in the path of maximum suction with the new type of hand nozzle recently introduced for use with industrial and commercial vacuum cleaners. The steel back horse hair brush snaps into two spring clips in the center of the nozzle opening. Prolonged field tests have shown this new type of nozzle to be highly efficient in dust and lint pickup. The nozzle is made of polished aluminum with resilient plastic bumper to prevent scratching or marring of surfaces. A 6 inch shank on the nozzle serves as a hand grip after insertion into the hose. **Breuer Electric Mfg. Co., Dept. MH, 5100 N. Ravenswood Ave., Chicago 40. (Key No. 23)**

Several New Models in Reach In Refrigerators

Several new developments have been announced in reach-in refrigerators by Koch Refrigerators. A sliding glass door refrigerator in 45 and 70 cubic foot size has doors framed in polished aluminum



and plastic. They are top suspended, easy-rolling and tight-sealing. The glass is double Thermopane, set in rubber. The sliding doors allow for maximum use of floor space. A similar 25 cubic foot refrigerator is also available in this 5800 series.

Standard remote and self-contained models Series 3800 and Series 2800 are now available as pass-through cabinets, with doors front and back. They are designed for use where it is advantageous to load the cabinet from both sides, or to load from one side and withdraw from the other. They are especially helpful in the middle of the workroom or kitchen, or in the wall between preparation and service areas.

Designed for use in institutions and other medium-sized food service establishments is the new Koch Series 6800. These hinged-door cabinets are designed to provide capacity, quality and economy for smaller commercial refrigerator applications. Model 6825 has forced convection system. Model 6821 has an ice-maker unit. **Koch Refrigerators, Inc., Dept. MH, North Kansas City, Mo. (Key No. 24)**

(Continued on page 216)

Year-Round Air Conditioning with Individual Room Control

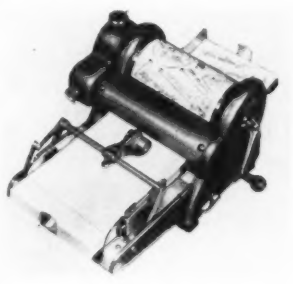
Individual room control of air comfort for any season of the year is possible with the new Dunham Vari-Temp Heating - Cooling - Ventilating Cabinets. The cabinets are neat, compact package units that can be floor mounted, vertically wall mounted, mounted flat on ceilings or inverted on walls. The same riser supplies hot water for heating and chilled water for cooling. Two blower fans mounted directly on double-end shaft motors eliminate external bearing, pulley and belt trouble. Rubber cushioning eliminates vibration in the manual mixing damper.

Aluminum fins on copper tubes supply heating and cooling elements. All elements are interchangeable for left or right hand supply. Cabinets are of 18-gauge furniture steel with end compartments that contain all piping and wiring. The removable front provides easy access to fans, heating element and replaceable filters. **C. A. Dunham Co., Dept. MH, 400 W. Madison St., Chicago 6. (Key No. 25)**

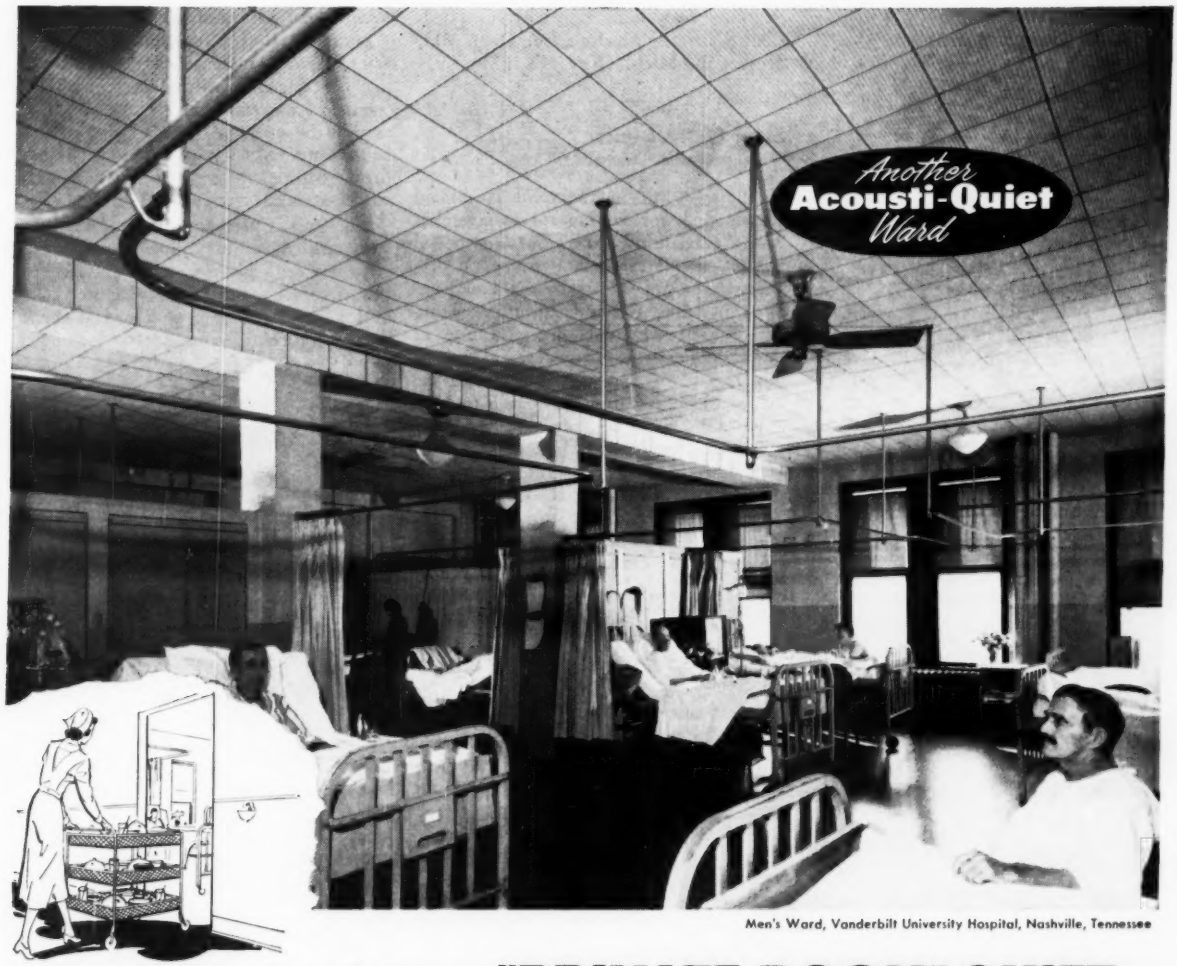
Pressure Setting Provided on Copy-Rite Duplicator

A "two-way" pressure control, permitting the retaining of pressure setting found to be most desirable for particular runs, is the outstanding feature of the new Model L-54 Copy-Rite Duplicator. The selected setting remains in effect until changed by the operator, even when the roller pressure is released after a job is finished. This feature is designed to assure the same pressure for all copies, eliminating experiments to match pressure adjustments.

The new model also features the Positive Margin Adjustment for raising and lowering the master to position copy exactly on each sheet and assure faster, neater work. The Complete Roller Release is designed to prevent "flat spots" and frequent roller replacement. The new Fluid Container of all-aluminum follows contour of the machine and the indicator



permits easy measurement of fluid level. **Wolber Duplicator & Supply Co., Dept. MH, 1203 Cortland St., Chicago 14. (Key No. 26)**



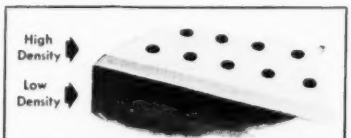
Men's Ward, Vanderbilt University Hospital, Nashville, Tennessee

Now, even wards have "PRIVATE ROOM" QUIET

With people walking and talking, equipment being moved, trays and dishes clattering—wards can be a noisy headache. But as hundreds of hospitals have discovered, routine noise need not be allowed to rob ward patients of the relaxing quiet they need for convalescence. It can be controlled . . . effectively and economically!

Low-Cost Solution

Acousti-Celotex Sound Conditioning is the answer. A sound-absorbing ceiling of Acousti-Celotex Tile checks noise in wards, operating and delivery rooms, nurseries, private rooms, corridors, lobbies, kitchens, utility rooms. It brings *soothing quiet* that helps patients rest and relax, and enables hospital personnel to work more efficiently.



DOUBLE-DENSITY—As the diagram shows, Acousti-Celotex Tile has two densities. *High density* face, for a more attractive finish of superior washability, easy paintability. *Low density* through remainder of tile, for greater sound-absorption value.

Easy Maintenance

Acousti-Celotex Tile is quickly installed at moderate cost. Requires no special maintenance. Its remarkable *double-density* feature (see diagram) prevents warping—gives a surface of unrivaled beauty and washability. Can be washed *repeatedly* and painted *repeatedly* without impairing its sound-absorbing properties!

GET A FREE ANALYSIS of the noise problem in your hospital without obligation. We will also send you free a factual booklet, "The Quiet Hospital." Mail coupon!

ACOUSTI-CELOTEX

TRADE MARK REGISTERED U. S. PAT. OFF.

Sound Conditioning

Products for Every Sound Conditioning Problem—The Celotex Corporation, 120 S. La Salle St. Chicago 3, Illinois • In Canada: Dominion Sound Equipments, Ltd., Montreal, Quebec

Mail coupon today

The Celotex Corporation, Dept. G-14
120 S. La Salle St., Chicago 3, Ill.

Without obligation, I would like . . .

☐ A free analysis of the noise problem in my hospital.

☐ A free copy of your booklet, "The Quiet Hospital."

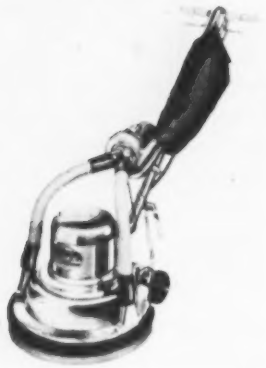
Name_____

Address_____

City_____ Zone____ State_____

What's New . . .

Buffer-Vac Attachment Cleans and Polishes



Vacuuming and polishing can be done in one operation with the new Buffer-Vac attachment recently introduced. It is available separately for quick and easy installation on the P-15 Floor Maintainer, or the P-15 is available complete with the new attachment.

A live rubber skirt which hugs the floor is attached to a specially designed head. With the high speed heavy-duty Universal motor, maximum suction is provided to pick up all loose particles, even from crevices and cracks. The moleskin bag which collects dirt, dust and other particles removed during the cleaning operation is easily emptied. **Clarke Sanding Machine Co., Dept. MH, Muskegan, Mich. (Key No. 27)**

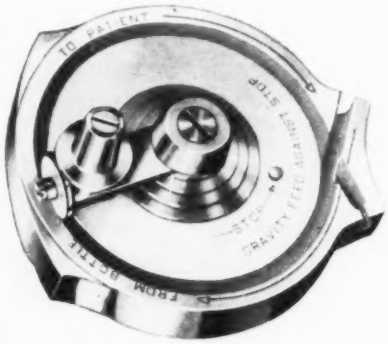
Steel Office Desks with Textolite Tops

The new MT-500 Textolite laminated plastic desk top is resistant to scratches and dents and impervious to pencil marks, ink and carbon stains. It has been developed jointly by General Fireproofing and General Electric, manufacturer of Textolite, for the line of Mode-Maker steel office desks. The new top is said to be the first successful attempt to bond laminated plastic to steel. The adherence between the steel top plate and the plastic is sufficiently great that extremes of temperature and humidity will not affect it. The desk top is easily cleaned with a damp cloth. **The General Fireproofing Co., Dept. MH, Youngstown, Ohio. (Key No. 28)**

Pump for Infusion or Gravity Feed

The new AO Sterile Fluids Pump is a portable instrument developed primarily for intravenous and intro-arterial infusion of blood, plasma and sterile fluids. It has also been found useful in non-medical applications where freedom of contamination is essential. The pump makes possible increased speed and positive control in transfusions. It may be clamped on any available irrigation stand or may be operated in the palm of the hand for emergency use. Standard transfusion equipment may be used with the aid of a simple adapter set.

The unit is precision made of stainless steel and aluminum alloy. It does not require sterilization since no part of the pump contacts the fluid. A single roller and a circular groove of a special shape permit the return from pressure infusion



to gravity feed without removing the tube. **American Optical Co., Dept. MH, Buffalo 15, N.Y. (Key No. 29)**

(Continued on page 218)

At the patient's bedside
In staff cafeterias
In the hospitality shop
— the all-around dinnerware is MELMAC®

Melmac dinnerware is so dependably break-resistant—seldom needs replacement

. . . it washes hygienically clean, by hand or by machine

. . . its beautiful colors and lustrous finish make foods look temptingly good

. . . it's so light in weight that nurses, kitchen help—all who handle it appreciate its deceptive lightness

. . . it stacks quietly—a big contribution to the hush-hush atmosphere that helps speed patients' recovery

More and more hospitals are using more and more dinnerware made of Melmac molding material!

Investigate Melmac dinnerware and the significant role it can play in *your* hospital. Ask your supplier for full information and samples —or write us for the illustrated booklet, "Of Melmac Dinnerware."

AMERICAN Cyanamid COMPANY
PLASTICS AND RESINS DIVISION
34F Rockefeller Plaza, New York 20, N. Y.

In Canada: North American Cyanamid Limited, Toronto and Montreal

What's New . . .

Simplified Procedure for Syringe Sterilization

Sterilization of syringes is facilitated with the new Vollrath Syringe Sterilizer. This stainless steel unit holds syringes and needles safely and the entire unit autoclaves without wrapping. Time, handling and breakage are saved by the use of this unit, according to the manufacturer. The unit is designed for use in wards, surgery, central supply and clinics. **The Vollrath Company, Dept. MH, Sheboygan, Wis. (Key No. 30)**

Contact Bond Cement for Installing Formica

An effective and satisfactory adhesive for on-the-job installation of Formica has been developed by The Formica Company. Known as Contact Bond Cement, it ensures a good bond between the Formica sheet and the surface being covered. With the new cement, Formica can be applied to the existing top of a desk, table or other object to be covered, as long as all cracks are filled, the old finish sanded off and rough spots smoothed out. **The Formica Company, Dept. MH, 4614 Spring Grove Ave., Cincinnati 32, Ohio. (Key No. 31)**

Non-Slip Floor Wax Is Self-Polishing

Saf-Floor is a rubber base which is self-polishing and non-slip. It is easily applied with a damp mop and requires no rubbing or buffing. It is cleaned with a neutral cleaner and retains its attractive appearance through long use. **E. J. Scarry & Co., Dept. MH, 1620 Market St., Denver 2, Colo. (Key No. 32)**

Chair Commemorates Hundredth Anniversary

To commemorate the one hundredth anniversary of the establishment of the company in this country, Thonet Industries has brought out a new chair known as the 100th Anniversary Chair. It is modern in concept with departures from current designs. The V-shaped laminated base is reenforced by stretchers and the molded seat and back are shaped for comfort and attractive appearance. An unusual arm arrangement of narrow, curved laminated strips adds to the grace and comfort.

A new bonding process joins back panel and back support of the all wood back, eliminating the need for screws. The new bonding process has been tested and proved to have superior power of adhesion.

The anniversary chair is available with arms or armless, with wood seats and wood backs or upholstered. It is

available in natural maple, walnut, mahogany or black enamel finish. **Thonet Industries Inc., Dept. MH, 1 Park Ave., New York 17. (Key No. 33)**

(Continued on page 220)

"We reduced maintenance time on our asphalt tile floors by 50%" –writes this hospital superintendent

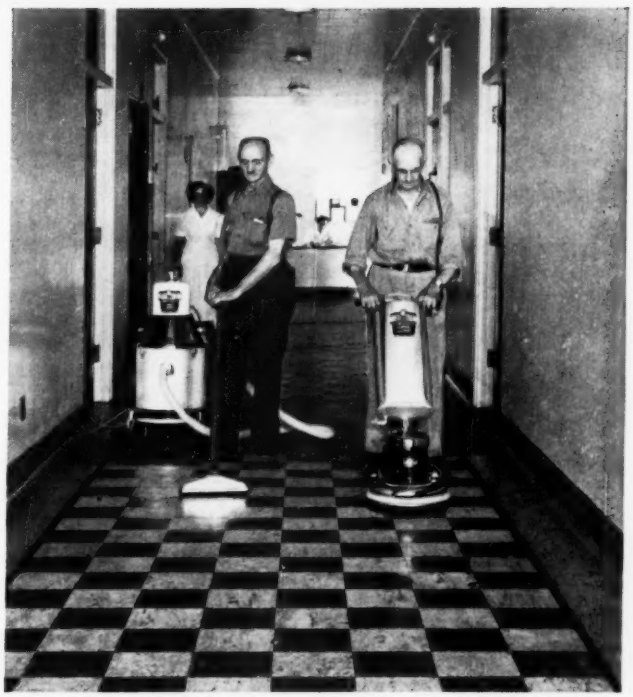
HERE'S HOW IT WAS DONE USING—

the MULTI-CLEAN METHOD

First step was to treat the floors with long lasting Multi-Clean Asphalt Tile Preserver followed by an application of Multi-Clean Anti-Slip Waterproof Floor Wax. This treatment, required about once a year, fortifies the floors against dirt, wear and scuff marks . . . protects the natural beauty, color and lustre of the tile . . . makes it easier to clean and keeps it clean longer.

Daily dry sweeping and weekly damp mopping with periodic buffing with a steel wool disc under a Multi-Clean Floor Machine is the extent of the maintenance required. This maintenance procedure takes about half the time of former methods because of the extra floor surface protection The Multi-Clean Method provides.

Whether you have asphalt tile or any other type of flooring you can save money because there is a Multi-Clean Method for every type of floor. Write today for more information on how you can protect, beautify and cut maintenance costs on your hospital floors.



Multi-Clean machines are engineered for unusually quiet operation. Your maintenance people can use them anytime—even at night—without disturbing patient's sleep. The Multi-Clean Hospital Vacuum Cleaner with its handy attachments simplifies dozens of cleaning jobs from floor to ceiling. Finished in gleaming chrome and hospital-white enamel.

FREE! HANDBOOK

"Your Floors and How to Maintain Them", is a valuable 44-page manual packed with information on all types of floors, and presenting The Multi-Clean Method of floor care for each. Mail coupon for your copy.

MULTI-CLEAN®

MAIL THIS COUPON TODAY!

MULTI-CLEAN PRODUCTS, INC.
2277 Ford Parkway, Dept. MH-1
St. Paul 1, Minnesota

Gentlemen: I would like the handbook, also more information on The Multi-Clean Method for:
☐ Asphalt Tile; ☐ Terrazzo; ☐ Wood. I'm interested in: ☐ Floor Machine; ☐ Hospital Vacuum.

*Name*_____

*Address*_____

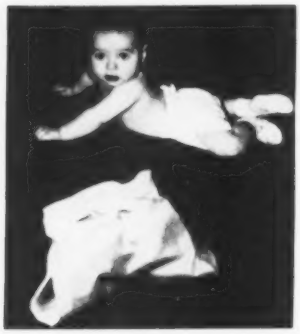
*City*_____ *Zone*___ *State*_____

What's New . . .

Individual Package For Ry-Krisp

Ry-Krisp, the cracker-like low calorie rye bread product, is now available in sanitary individual serving cellophane packages. With the new package service is quick and easy and exact portion control is possible. The new pack has been developed for institutional and mass feeding use. **Ralston Purina Co., Dept. MH, Checkerboard Square, St. Louis 2, Mo. (Key No. 34)**

Tie-On Diaper Needs No Pins



A new diaper is now available which ties on the infant, requiring no pins, thus eliminating the possibility of accidental pricking or scratching of infant or nurse. It will fit the baby without folding and is offered in three sizes: small, medium and large. The Tie-On Diaper is padded with five layers of white birdseye and the diaper is easily laundered. The tape ties are long enough to tie easily and securely but not long enough to tangle in any type of washing machine or dryer. The diaper ties on in front and in back, stays on securely and is tailored to fit the infant comfortably. **Nansen Co., Dept. MH, 8 Allen St., Batavia, N.Y. (Key No. 35)**

Water Cooler for Wall Fountain

Built to operate efficiently within a louvered wall aperture the new Wal-Pak water cooler is designed to supply uniformly cool water to a wall fountain of any style selected to harmonize with an interior. The louvered panel is flush-mounted with the wall and toned to match, leaving an unbroken wall surface and preventing collection of corridor dirt. The cooling unit is completely concealed, silent and safe-guarded against abuse. Wal-Pak is suitable for new construction or modernization and can be installed in the wall, under floor or counter to supply chilled water to any new or existing outlets. It is available in two sizes, to supply 50 degree water for 50 to 100 persons per hour at one or two fountains. **Filtrine Manufacturing Co., Dept. MH, 53 Lexington Ave., Brooklyn 38, N. Y. (Key No. 36)**

(Continued on page 222)

Light Weight Vacuum Empties Easily

The unique swivel-action nozzle on the new Regina Electrickbroom adjusts to the angle of the handle. Positive suction is thus assured at all times. It is streamlined in design, combining lightness of weight with ease of operation and easy emptying of the dirt cup. The cleaner is readily maneuvered around and under furniture and can be used on wood, linoleum and other hard surfaced floors. It is ruggedly constructed and the new model is finished in gray with accents of red. **The Regina Corp., Dept. MH, 54 West Cherry St., Rahway, N.J. (Key No. 37)**

"Fresh up" with Seven-Up!

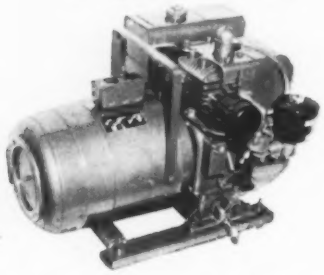
The All-Family Drink... so pure,
so good, so wholesome for everyone!

You like it... it likes you!

GET A FAMILY SUPPLY OF 24 BOTTLES.
Buy 7-Up by the case. Or get the handy 7-Up FAMILY PACK. Easy-lift center handle, easy to store.

What's New . . .

Three Models Added To Lighting Plant Line



Super-excited generators with two pole design directly attached to the engine crank shaft are features of the new Katolight plants. The three new models recently introduced are versatile machines generating standard 60 cycle alternating current. The engine on the 1350 watt size is a 9 FB Briggs and Stratton air-cooled model. The complete unit weighs only 146 pounds and is equipped with rubber mounted type isolators, receptacles and carrying handles.

The engines in the new unit are run on kerosene. When desired the engines are arranged with a two compartment tank starting on gasoline and running on kerosene. The new series is available in 650, 1350 and 2000 watt capacities. **Katolight Corp., Dept MH, 624 North Front St., Mankato, Minn. (Key No. 38)**

Liquid Surgical Dressing Is Sprayed On

Surgical and traumatic wounds, burns, abrasions and similar conditions can be dressed with Aeroplast, a new liquid, "spray-on" dressing. It can be sprayed directly onto the lesion from a self-contained aerosol "bomb." It forms a transparent, flexible, occlusive plastic film which seals against contamination and seals in vital fluids. It is non-toxic, non-sensitizing and mildly bacteriostatic, according to the manufacturer. Dressings may be peeled off easily, without discomfort, at any time. **Aeroplast Corporation, Dept. MH, Dayton 3, Ohio. (Key No. 39)**

Improved Case for Insulation Tester

An improved case has been designed which permits the Midget Megger Insulation Tester to be operated without removal from the case. It can be operated simply by opening the lid and turning it back. The leads are stored in a handy compartment under the instrument and the unit contains its own unfailing source of test current in a built-in hand generator. The cases are available separately at moderate cost. **James G. Biddle Co., Dept. MH, 1316 Arch St., Philadelphia 7, Pa. (Key No. 40)**

(Continued on page 224)

Support Holds Patient Comfortably in Chair

The Posey Patient Support is designed to support patients in chairs who otherwise might not be able to get out of bed. It can be used on wheel chairs or conventional chairs and holds the patient firmly but comfortably upright. The arrangement of the straps gives firm support to hold the shoulders upright, to hold the mid-section against the back of the chair, and to keep the patient's hips from moving forward. The patient is safe in his

chair while out of bed. **J. T. Posey Company, Dept. MH, 801 N. Lake Ave., Pasadena 6, Calif. (Key No. 41)**

What's New . . .

Pharmaceuticals

Combistrep

Combistrep is a combination of equal parts of streptomycin and dihydrostreptomycin which has proved as efficacious as the drugs used singly, yet with a decrease in the side effects of both. Combistrep is packaged in dry powder form for the preparation of solutions for intramuscular injection. It is available in silicone-treated, "drain-clear" vials in both 1 Gm. and 5 Gm. sizes, and is stable for 48 months at room temperature. **Pfizer Laboratories, Dept. MH, 630 Flushing Ave., Brooklyn 6, N.Y. (Key No. 42)**

Bristamin APC Tablets

Bristamin APC Tablets combine phenyltoloxamine with aspirin, phenacetin and caffeine. It is designed for the rapid and measurable relief from both local coryza manifestations and constitutional symptoms. In addition to suppression of rhinorrhea and allergic-like symptoms, the tablets provide relief of headache and muscular aches and pains accompanying the common cold. The tablets are supplied in bottles of 100 and 1000. **Bristol Laboratories Inc., Dept. MH, Syracuse 1, N.Y. (Key No. 43)**

Crysdimycin A. S.

Crysdimycin A.S. is a high potency antibiotic combination with a broad antibacterial spectrum. It is effective against gram-negative and gram-positive organisms and is valuable in mixed or undiagnosed infections. This aqueous suspension of Squibb procaine penicillin in streptomycin and dihydrostreptomycin solution is indicated as a prophylaxis before and after surgery in a contaminated site as well as for the treatment of various types of infections. It is supplied in 5 dose vials and is stable for one year if stored below 15 degrees C. **E. R. Squibb & Sons, Dept. MH, 32-14 Northern Blvd., Long Island City 1, N. Y. (Key No. 44)**

A-P-Cillin

White's A-P-Cillin tablets combine acetylsalicylic acid, phenacetin and caffeine for analgesic and antipyretic action, antihistamine for local symptomatic relief and penicillin for prevention and control of secondary bacterial infections. It is designed for the treatment of acute upper respiratory infections, including the common cold. It is supplied in bottles of 50 and 500 tablets. **White Laboratories, Inc., Dept. MH, Kenilworth, N.J. (Key No. 45)**

Sustagen

Sustagen is a complete nutriment, supplying a balanced amount of protein, fat, carbohydrate, vitamins and minerals, designed for tube feeding. It is the result of long research and clinical investigation and provides a new approach to tube feeding, overcoming diarrhea, cramps and nausea associated with tube feeding mixtures. Mead's new Tube Feeding Set provides ease of administration. The extremely small, smooth plastic tubing is easily inserted and swallowed almost without sensation as it is half the size of the ordinary small rubber tube. Sustagen can also be used orally by patients on liquid diets. **Mead Johnson & Company, Dept. MH, Evansville 21, Ind. (Key No. 46)**

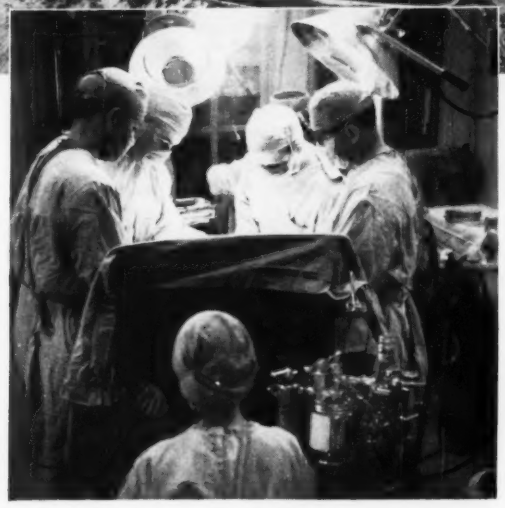
Cortef Acetate, Ointment

Cortef Acetate, Ointment contains hydrocortisone-compound F in a bland, non-irritating base. It is applied topically to the skin and exerts a rapid and prolonged anti-inflammatory effect. Local edema, hyperemia, cellular infiltration and pruritus, particularly in allergic conditions, are readily controlled. It is supplied in 1 and 2½ per cent 5 Gm. tubes. **The Upjohn Company, Dept. MH, Kalamazoo, Mich. (Key No. 47)**

(Continued on page 226)

Louisville's New Veterans' Hospital protected by

ONAN *Emergency* ELECTRIC PLANT



When storms, floods, fires or breakdowns interrupt electric power, the Onan Model 10EL, 10,000-watt electric plant starts automatically. Within seconds it provides a flow of current for essential uses, safeguarding patients and staff.

Onan Emergency Electric Plants, available in capacities to 55,000 watts, meet all the requirements for standby electric power in modern hospitals. Hundreds of installations have proved their dependability.

Our engineering department will help you compute your standby power requirements and suggest a plant to fit your needs. Write.

Gasoline-powered electric plants: 1,000 to 50,000 watts.
Diesel-powered electric plants: 3,000 to 55,000 watts.

Write for special folder on Hospital Standby Power!

D. W. ONAN & SONS INC.

4939 University Ave. S.E., • Minneapolis 14, Minn.

Onan ELECTRIC PLANTS

What's New . . .

Elorine Sulfate

Elorine Sulfate is an improved anticholinergic agent for gastro-intestinal dysfunction. It relieves spasm and hypermotility of the gastro-intestinal tract and is an adjunct in peptic ulcer therapy. Clinical data is said to show profound inhibiting effect on intestinal motility with indicated dosages. It is supplied in 25 and 50 mg. pulvules. **Eli Lilly & Co., Dept. MH, Indianapolis 6, Ind. (Key No. 48)**

Blutene

Blutene is an orally effective agent for the treatment and prevention of abnormal uterine bleeding of functional origin. It is supplied as a mixture of the chloride and sulfate salts, in 100-mg. sugar-coated tablets, in bottles of 25 and 100. **Abbott Laboratories, Dept. MH, North Chicago, Ill. (Key No. 49)**

Diamox

Diamox is a non-mercurial diuretic for oral administration. It is designed for treatment of patients suffering from edema resulting from congestive heart failure. It increases the output of salt and water from the kidneys. The product is easily administered, has low toxicity and is free from irritating effects. **Lederle Laboratories Div., American Cyanamid Co., Dept. MH, 30 Rockefeller Plaza, New York 20. (Key No. 50)**

Daprisal

Daprisal is a new analgesic preparation designed to relieve the physical aspects of pain as well as the psychic aspects of pain. The effectiveness of the product, as a non-narcotic analgesic, is the result of multiple synergism among its components, according to the manufacturer. Daprisal contains Dexedrine Sulfate, amobarbital, acetylsalicylic acid and phenacetin. **Smith, Kline & French Laboratories, Dept. MH, 1530 Spring Garden St., Philadelphia 1, Pa. (Key No. 51)**

Intraderm Tyrothricin Cream

Intraderm Tyrothricin Cream is the new name for the product formerly known as Bactratycin Ointment. It is a topical preparation containing tyrothricin in a special base making the antibiotic more penetrating for use in various infections of the skin. **Wallace Laboratories, Inc., Dept. MH, New Brunswick, N.J. (Key No. 52)**

(Continued on page 228)

Product Literature

• Specifications on **Joseph Goder Disposalls** of all sizes are given in a folder issued by Joseph Goder Incinerators, 5121 N. Ravenswood Ave., Chicago 40. These incinerators, for heavy duty use in handling all types of refuse including garbage, rubbish, trash and pathological waste, are described in the folder which stresses their use in hospitals, and other institutions. **Key No. 53)**

• A new bulletin has been released by the Security-Connecticut Insurance Companies, Whitney Ave., New Haven, Conn. It covers two relatively new types of protection, which should be of interest to hospital administrators, covering **Valuable Papers and Records Insurance and Accounts Receivable Insurance.** Both new policies insure against practically all risks and rates are based on the fire insurance rates where the property is located. **(Key No. 54)**

• **Public address equipment** manufactured by Newcomb Audio Products Co., 6824 Lexington Ave., Hollywood, Calif., is described and illustrated in a new 20 page catalog recently released. All three lines of Newcomb amplifiers, portable systems and accessories are covered, as well as Newcomb rack and panel assemblies. **(Key No. 55)**

What's New . . .

• **"An Important Message to Your Auxiliary"** is the title of an attractive booklet on Oxygen Therapy Apparatus and Methods Used in Hospitals published by National Cylinder Gas Co., 840 N. Michigan Ave., Chicago 11. Written in an easily-understood style for hospital auxiliary members, the booklet explains the importance of oxygen therapy and describes the equipment needed by hospitals. Oxygen therapy methods and apparatus are described and illustrated, including piping systems, costs are given, the value of piped oxygen is discussed and the suggestion is made that officers of the auxiliary consult the hospital administrator for further information. **(Key No. 56)**

• **"Castle Pressure Sterilizers (Cylindrical)"** are discussed in a new catalog issued by Wilmot Castle Company, 1255 University Ave., Rochester 7, N. Y. Photographs and line drawings illustrate the descriptive text and there are tables giving sizes and capacities. **(Key No. 57)**

• One of the earliest installations of the dictating-transcribing system developed by Standard Business Machines Mfg. Co., 1948 Third Ave., Huntington, W. Va., is described in a booklet published by that company and entitled **"Success Story—From Real Life."** How the system was engineered to the user's special requirements, how it operates, what are its advantages and how it saves money are some of the subjects discussed. **(Key No. 58)**

• A color chart which shows the seven new colors recently added to the line of **Vina-Lux Reenforced Vinyl Tile,** and which pictures all patterns now available in this line, is a part of a folder recently published by Uvalde Rock Asphalt Co., P. O. Box 531, San Antonio 6, Tex. Descriptive information on this flexible, smooth surfaced floor tile is included. **(Key No. 59)**

• **Melco Oxygen Therapy Equipment** is fully covered in a new catalog issued by the Medical Equipment Division, Melchior, Armstrong, Dessau Company, Ridgefield, N.J. Detailed information on Melco oxygen therapy equipment and accessories is supplemented by photographs of each item. Any item is quickly found through the index which covers subject and product. **(Key No. 60)**

• The importance of good floors in institutions and other public buildings is discussed in a 20 page booklet on **"Floors"** published by The Monroe Company, Inc., 10703 Quebec Ave., Cleveland 6, Ohio. The brochure is the result of many years of Monroe research in flooring problems and contains a sample of a floor analysis form to assist maintenance men in determining floor requirements. **(Key No. 61)**

• **Supplements to Catalogs No. 103 and 104** have been issued by Huntington Chair Corporation, Huntington, W. Va. Chairs, settees and tables are illustrated and described in the Supplement to Catalog No. 103 and Studio Units, especially suitable for nurses' homes and other personnel housing, are covered in the Supplement to Catalog No. 104. **(Key No. 62)**

• A new circular describing **Hild Wet-or-Dry Vacuums, Models 115 and 155,** has been issued by Hild Floor Machine Co., 740 W. Washington Blvd., Chicago 6. A diagram on the first page illustrates and explains the principle of the Hild "By-Pass" Motor. Complete descriptions and specifications on both models, together with illustrations of their uses, are included. **(Key No. 63)**

• Five 8-page booklets and one 4-page folder on **Wakefield lighting** for institutions and commercial buildings are available from The F. W. Wakefield Brass Co., Vermilion, Ohio. Each booklet contains engineering and installation data and the descriptive text is illustrated. Four booklets deal with the four types of equipment known as "Wakefield Geometrics," the luminous ceiling family with rigid-arch swing-down Plexiglas diffusers which are modular in application. A fifth booklet deals with the 1953 model direct-indirect louvered suspended fixture. **(Key No. 64)**

• A digest of the many uses of the Time Switch is offered in a booklet, **"The Story of the Electric Watchman,"** offered by the National Electrical Manufacturers Assn., Time Switch Section, 155 E. 44th St., New York 17. The booklet describes Time Switches as a factor in the lives of all types of people and tells why and how. **(Key No. 65)**

• The complete line of Harvard mobile metal bed frames and metal bed assemblies is featured in a new combined **Catalog and Merchandising Guide** published by The Harvard Manufacturing Co., 6201 Woodland Ave., Cleveland 4, Ohio. The 32 page booklet gives information on metal bed carriers and how they can be used. It is illustrated with photographs and drawings of many bed frame applications, and should be of particular interest for furnishing nurses' homes and other personnel quarters. **(Key No. 66)**

• Two catalogs on **x-ray accessories** have been brought out by Wolf X-Ray Products, Inc., 93 Underhill Ave., Brooklyn 38, N.Y. One covers descriptive information and illustrations of Wolf Illuminators, Safelights and Filing Cabinets, and the other discusses Wolf Supreflex X-Ray Gloves and Aprons. **(Key No. 67)**

• Attractively illustrated with photographs, the new Eichenlaub **Catalog of Hospital and Dormitory Furniture** is loose-leaf type. Full descriptive information is given together with construction information on the line. The catalog is available from Eichenlaubs, 3501 Butler St., Pittsburgh 1, Pa. **(Key No. 68)**

• **"Ohio Oxygen Therapy and Resuscitation Equipment"** is the title of a new 24 page catalog covering the complete line of this equipment manufactured by the Ohio Chemical & Surgical Equipment Co., Madison 10, Wis. Illustrations and descriptive information on oxygen tents, portable therapy units, inhalation equipment, humidifiers, aerosol units, resuscitators and parts and accessories are included in the catalog, which is fully indexed. **(Key No. 69)**

• **"Cooking the Modern Way"** is the title of a 44 page booklet issued by the Groen Mfg. Co., 4535 W. Armitage Ave., Chicago 39. The booklet is designed to assist those responsible for food service in institutions and reviews established food principles in the light of most recent information on nutrition and cooking methods. It emphasizes the use of steam-jacketed kettles in the production of high quality food in quantities and covers the making of coffee, and the cooking of vegetables, meat, poultry, soup, cereal, eggs, fruits and desserts. **(Key No. 70)**

• **Floor plans for food service departments** in various types of institutions are shown in a new booklet on designing and engineering services for food service facilities issued by J. E. Stephens Associates, Inc., 320 W. Lafayette Blvd., Detroit 26, Mich. Actual layout of kitchen and cafeteria in hospitals of various sizes and types are shown as well as cafeteria counters, construction problems, types of equipment and refrigerator systems. **(Key No. 71)**

• **"Hospitals Cannot Afford Darkness"** is the challenging title of a booklet recently released by Caterpillar Tractor Co., Peoria 8, Ill. It covers a study of emergency power for hospitals through standby Diesel-electric sets and pictures actual hospital installations. How automatic controls prevent power stoppages and the importance of this safeguard are discussed. **(Key No. 72)**

Supplier's News

Johnson Service Company, 507 E. Michigan St., Milwaukee 2, Wis., manufacturer of automatic temperature and air conditioning control systems, announces the opening of six new branch offices, in **Champaign, Ill.; Detroit, Mich.; Greensboro, N.C.; Lubbock, Texas; Miami, Fla.,** and **Pensacola, Fla.**

PRODU

Inde

Key

1 Bone Saw Carrying Case
Orthopedic Frame Company

2 Printing Calculator
Remington Rand Inc.

3 Cyclo-Flush Bedpan Washer
American Sterilizer Company

4 Oxweld Stationary Manifolds
Linde Air Products Company

5 Medical Utility Glove
The Pioneer Rubber Company

6 Tomac Medicine Cart
American Hospital Supply Co.

7 Explosion-Proof Switches
Appleton Electric Company

8 Weck Cleaner
Edward Weck & Company

9 Ideal Thermo-Mist
The Swartzbaugh Mfg. Company

10 K-40 Rectal Tube
Pharmaseal Laboratories

11 Plastic Bedside Drainage Tube
Sterilon Corporation

12 Weyrauch Float Valve
American Cystoscope Maker Inc.

13 Folding Wheel Chair
Colson Corporation

14 Conduct-O-Tile Flooring
American-Olean Tile Company

15 Model ST-E Steam-It
The Market Forge Company

16 Frestep Aisle Runner
Fremont Rubber Company

17 Model 1220 Food Mixer
Universal Industries

18 Tray-Washing Rack
Metropolitan Wire Goods Corp.

19 Dustronic Electrostatic Air Cleaner
Radex Corporation

20 Cubicle Screen
Polecats Incorporated

21 Cof-flator Cough Machine
O.E.M. Corporation

22 Recorder-Reproducer
The Soundscriber Corporation

23 Vacuum Cleaner Hand Nozzle
Breuer Electric Mfg. Company

24 Reach-In Refrigerators
Koch Refrigerators Inc.

25 Air Conditioning
C. A. Dunham Company

Index

USE THIS CARD

(We pay the postage)

This card is detachable and is provided for the convenience of our subscribers, and those to whom they pass their copies, in obtaining information on products and services advertised in this issue or described in the "What's New" Section. See reverse side.

January, 1954

Please ask the manufacturers, indicated by the numbers I have circled, to send further literature and information provided there is no charge or obligation.

WHAT'S NEW

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19
20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38
39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57
58 59 60 61 62 63 64 65 66 67 68 69 70 71 72

ADVERTISEMENTS

73 74 75 76 77 78 79 80 81 82 83 84 85 86 87 88
89 90 91 92 93 94 95 96 97 98 99 100 101 102 103 104
105 106 107 108 109 110 111 112 113 114 115 116 117 118 119 120
121 122 123 124 125 126 127 128 129 130 131 132 133 134 135 136
137 138 139 140 141 142 143 144 145 146 147 148 149 150 151 152
153 154 155 156 157 158 159 160 161 162 163 164 165 166 167 168
169 170 171 172 173 174 175 176 177 178 179 180 181 182 183 184
185 186 187 188 189 190 191 192 193 194 195 196 197 198 199 200
201 202 203 204 205 206 207 208 209 210 211 212 213 214 215 216
217 218 219 220 221 222 223 224 225 226 227 228 229 230 231 232
233 234 235 236 237 238 239 240 241 242 243 244 245 246

NAME _____ TITLE _____

INSTITUTION _____

ADDRESS _____ CITY _____ ZONE _____ STATE _____

What's New . . .

• **"An Important Message to Your Auxiliary"** is the title of an attractive booklet on Oxygen Therapy Apparatus and Methods Used in Hospitals published by National Cylinder Gas Co., 840 N. Michigan Ave., Chicago 11. Written in an easily-understood style for hospital auxiliary members, the booklet explains the importance of oxygen therapy and describes the equipment needed by hospitals. Oxygen therapy methods and apparatus are described and illustrated, including piping systems, costs are given, the value of piped oxygen is discussed and the suggestion is made that officers of the auxiliary consult the hospital administrator for further information. **(Key No. 56)**

• **"Castle Pressure Sterilizers (Cylindrical)"** are discussed in a new catalog issued by Wilmot Castle Company, 1255 University Ave., Rochester 7, N. Y. Photographs and line drawings illustrate the descriptive text and there are tables giving sizes and capacities. **(Key No. 57)**

• One of the earliest installations of the dictating-transcribing system developed by Standard Business Machines Mfg. Co., 1948 Third Ave., Huntington, W. Va., is described in a booklet published by that company and entitled **"Success Story—From Real Life."** How the system was engineered to the user's special requirements, how it operates, what are its advantages and how it saves money are some of the subjects discussed. **(Key No. 58)**

• A color chart which shows the seven new colors recently added to the line of **Vina-Lux Reenforced Vinyl Tile,** and which pictures all patterns now available in this line, is a part of a folder recently published by Uvalde Rock Asphalt Co., P. O. Box 531, San Antonio 6, Tex. Descriptive information on this flexible, smooth surfaced floor tile is included. **(Key No. 59)**

• **Melco Oxygen Therapy Equipment** is fully covered in a new catalog issued by the Medical Equipment Division, Melchior, Armstrong, Dessau Company, Ridgefield, N.J. Detailed information on Melco oxygen therapy equipment and accessories is supplemented by photographs of each item. Any item is quickly found through the index which covers subject and product. **(Key No. 60)**

• The importance of good floors in institutions and other public buildings is discussed in a 20 page booklet on **"Floors"** published by The Monroe Company, Inc., 10703 Quebec Ave., Cleveland 6, Ohio. The brochure is the result of many years of Monroe research in flooring problems and contains a sample of a floor analysis form to assist maintenance men in determining floor requirements. **(Key No. 61)**

• **Supplements to Catalogs No. 103 and 104** have been issued by Huntington Chair Corporation, Huntington, W. Va. Chairs, settees and tables are illustrated and described in the Supplement to Catalog No. 103 and Studio Units, especially suitable for nurses' homes and other personnel housing, are covered in the Supplement to Catalog No. 104. **(Key No. 62)**

• A new circular describing **Hild Wet-or-Dry Vacuums, Models 115 and 155,** has been issued by Hild Floor Machine Co., 740 W. Washington Blvd., Chicago 6. A diagram on the first page illustrates and explains the principle of the Hild "By-Pass" Motor. Complete descriptions and specifications on both models, together with illustrations of their uses, are included. **(Key No. 63)**

• Five 8-page booklets and one 4-page folder on **Wakefield lighting** for institutions and commercial buildings are available from The F. W. Wakefield Brass Co., Vermilion, Ohio. Each booklet contains engineering and installation data and the descriptive text is illustrated. Four booklets deal with the four types of equipment known as "Wakefield Geometrics," the luminous ceiling family with rigid-arch swing-down Plexiglas diffusers which are modular in application. A fifth booklet deals with the 1953 model direct-indirect louvered suspended fixture. **(Key No. 64)**

• A digest of the many uses of the Time Switch is offered in a booklet, **"The Story of the Electric Watchman,"** offered by the National Electrical Manufacturers Assn., Time Switch Section, 155 E. 44th St., New York 17. The booklet describes Time Switches as a factor in the lives of all types of people and tells why and how. **(Key No. 65)**

• The complete line of Harvard mobile metal bed frames and metal bed assemblies is featured in a new combined **Catalog and Merchandising Guide** published by The Harvard Manufacturing Co., 6201 Woodland Ave., Cleveland 4, Ohio. The 32 page booklet gives information on metal bed carriers and how they can be used. It is illustrated with photographs and drawings of many bed frame applications, and should be of particular interest for furnishing nurses' homes and other personnel quarters. **(Key No. 66)**

• Two catalogs on **x-ray accessories** have been brought out by Wolf X-Ray Products, Inc., 93 Underhill Ave., Brooklyn 38, N.Y. One covers descriptive information and illustrations of Wolf Illuminators, Safelights and Filing Cabinets, and the other discusses Wolf Supreflex X-Ray Gloves and Aprons. **(Key No. 67)**

• Attractively illustrated with photographs, the new Eichenlaub **Catalog of Hospital and Dormitory Furniture** is loose-leaf type. Full descriptive information is given together with construction information on the line. The catalog is available from Eichenlaubs, 3501 Butler St., Pittsburgh 1, Pa. **(Key No. 68)**

• **"Ohio Oxygen Therapy and Resuscitation Equipment"** is the title of a new 24 page catalog covering the complete line of this equipment manufactured by the Ohio Chemical & Surgical Equipment Co., Madison 10, Wis. Illustrations and descriptive information on oxygen tents, portable therapy units, inhalation equipment, humidifiers, aerosol units, resuscitators and parts and accessories are included in the catalog, which is fully indexed. **(Key No. 69)**

• **"Cooking the Modern Way"** is the title of a 44 page booklet issued by the Groen Mfg. Co., 4535 W. Armitage Ave., Chicago 39. The booklet is designed to assist those responsible for food service in institutions and reviews established food principles in the light of most recent information on nutrition and cooking methods. It emphasizes the use of steam-jacketed kettles in the production of high quality food in quantities and covers the making of coffee, and the cooking of vegetables, meat, poultry, soup, cereal, eggs, fruits and desserts. **(Key No. 70)**

• **Floor plans for food service departments** in various types of institutions are shown in a new booklet on designing and engineering services for food service facilities issued by J. E. Stephens Associates, Inc., 320 W. Lafayette Blvd., Detroit 26, Mich. Actual layout of kitchen and cafeteria in hospitals of various sizes and types are shown as well as cafeteria counters, construction problems, types of equipment and refrigerator systems. **(Key No. 71)**

• **"Hospitals Cannot Afford Darkness"** is the challenging title of a booklet recently released by Caterpillar Tractor Co., Peoria 8, Ill. It covers a study of emergency power for hospitals through standby Diesel-electric sets and pictures actual hospital installations. How automatic controls prevent power stoppages and the importance of this safeguard are discussed. **(Key No. 72)**

Supplier's News

Johnson Service Company, 507 E. Michigan St., Milwaukee 2, Wis., manufacturer of automatic temperature and air conditioning control systems, announces the opening of six new branch offices, in **Champaign, Ill.; Detroit, Mich.; Greensboro, N.C.; Lubbock, Texas; Miami, Fla.,** and **Pensacola, Fla.**

PRODUCT INFORMATION

Index to "What's New"

Pages 207-228

Key

1 Bone Saw Carrying Case
Orthopedic Frame Company

2 Printing Calculator
Remington Rand Inc.

3 Cyclo-Flush Bedpan Washer
American Sterilizer Company

4 Oxweld Stationary Manifolds
Linde Air Products Company

5 Medical Utility Glove
The Pioneer Rubber Company

6 Tomac Medicine Cart
American Hospital Supply Co.

7 Explosion-Proof Switches
Appleton Electric Company

8 Weck Cleaner
Edward Weck & Company

9 Ideal Thermo-Mist
The Swartzbaugh Mfg. Company

10 K-40 Rectal Tube
Pharmaseal Laboratories

11 Plastic Bedside Drainage Tube
Sterilon Corporation

12 Weyrauch Float Valve
American Cystoscope Maker Inc.

13 Folding Wheel Chair
Colson Corporation

14 Conduct-O-Tile Flooring
American-Olean Tile Company

15 Model ST-E Steam-It
The Market Forge Company

16 Prestop Aisle Runner
Fremont Rubber Company

17 Model 1220 Food Mixer
Universal Industries

18 Tray-Washing Rack
Metropolitan Wire Goods Corp.

19 Dustronic Electrostatic Air Cleaner
Radex Corporation

20 Cubicle Screen
Polecats Incorporated

21 Cof-flator Cough Machine
O.E.M. Corporation

22 Recorder-Reproducer
The Soundscriber Corporation

23 Vacuum Cleaner Hand Nozzle
Breuer Electric Mfg. Company

24 Reach-In Refrigerators
Koch Refrigerators Inc.

25 Air Conditioning
C. A. Dunham Company

Key

26 Model L-54 Duplicator
Wolber Duplicator & Supply Company

27 Buffer-Vac Attachment
Clarke Sanding Machine Company

28 Textolite Desk Top
The General Fireproofing Company

29 Sterile Fluids Pump
American Optical Company

30 Syringe Sterilizer
The Vollrath Company

31 Contact Bond Cement
The Formica Company

32 Non-Slip Floor Wax
E. J. Scarry & Company

33 100th Anniversary Chair
Thonet Industries Inc.

34 Individual Package Ry-Krisp
Ralston Purina Company

35 Pinless Diapers
Nansen Company

36 Water Cooler
Flitrine Mfg. Company

37 Electrickbroom
The Regina Corporation

38 Emergency Lighting Plants
Katolight Corporation

39 Liquid Surgical Dressing
Aeroplast Corporation

40 Midget Tester Case
James G. Biddle Company

41 Patient Support
J. T. Posey Company

42 Combistrep
Pfizer Laboratories

43 Bristamin APC Tablets
Bristol Laboratories Inc.

44 Crysdimycin A.S.
E. R. Squibb & Sons

45 A-P-Cillin
White Laboratories Inc.

46 Sustagen
Mead Johnson & Company

47 Cortef Acetate, Ointment
The Upjohn Company

48 Elorine Sulfate
Eli Lilly & Company

49 Blutene
Abbott Laboratories

Key

50 Diamax
Lederle Laboratories

51 Daprisal
Smith, Kline & French Laboratories

52 Intraderm Tyrothricin Cream
Wallace Laboratories Inc.

53 Folder on Disposalls
Joseph Goder Incinerators

54 Valuable Papers Insurance
Connecticut Indemnity Company

55 Public Address Equipment
Newcomb Audio Products Company

56 "An Important Message to Your Auxiliary"
National Cylinder Gas Company

57 Castle Pressure Sterilizers
Wilmot Castle Company

58 Success Story—From Real Life
Standard Business Machines Mfg. Company

59 Vina-Lux Reenforced Vinyl Tile
Uvalde Rock Asphalt Company

60 Oxygen Therapy Equipment
Melchior, Armstrong, Dessau Company, Inc.

61 Booklet on "Floors"
The Monroe Company Inc.

62 Catalog Supplements
Huntington Chair Corporation

63 Wet-or-Dry Vacuums
Hild Floor Machine Company

64 Booklets on Lighting
F. W. Wakefield Brass Company

65 "The Story of the Electric Watchman"
National Electrical Manufacturers Assn.

66 Metal Bed Frames
Harvard Manufacturing Company

67 X-Ray Accessories Catalog
Wolf-X-Ray Products Inc.

68 Hospital and Dormitory Furniture
Eichenlaubs

69 Oxygen and Resuscitation Equipment
Ohio Chemical and Surgical Equipment Co.

70 "Cooking the Modern Way"
Groen Mfg. Company

71 Food Service Facilities
J. E. Stephens Associates

72 Hospitals Cannot Afford Darkness
Caterpillar Tractor Company

Index to Products Advertised

INDEX CONTINUED ON FOLLOWING PAGE →

USE THIS CARD

(We pay the postage)

This card is detachable and is provided for the convenience of our subscribers, and those to whom they pass their copies, in obtaining information on products and services advertised in this issue or described in the "What's New" Section. See reverse side.

FIRST CLASS
PERMIT NO. 137
SEC. 34.9 P. L. & R.
CHICAGO, ILL.

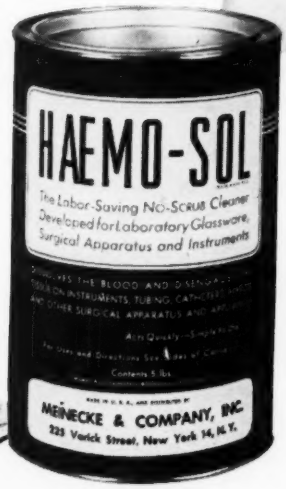
BUSINESS REPLY CARD
No Postage Stamp Necessary if Mailed in the United States

4 CENT POSTAGE WILL BE PAID BY

THE MODERN HOSPITAL
919 NORTH MICHIGAN AVENUE
CHICAGO 11, ILLINOIS

ed — Continued

ONLY HAEMO-SOL GIVES HAEMO-SOL RESULTS



Haemo-Sol is the pioneer blood-solvent cleanser specifically formulated for exacting hospital and laboratory use. With Haemo-Sol, blood dissolves, tissue, mucous and all other foreign substances *completely* disengage on immersion alone. Equally effective, safe and efficient for cleansing metal, rubber, glass, Haemo-Sol's controlled pH also eliminates any etching effect on glass, inhibits rust, prevents microscopic pitting of stainless steel. The ideal pre-sterilization technique, Haemo-Sol cleanses surgical instruments, apparatus, clinical glassware without manual scrubbing.

Because Haemo-Sol contains no harsh caustic irritants frequently found in other preparations, and is further fortified with Urea, it may be used by even those with the most tender skin, with complete safety.

Remember, only Haemo-Sol gives Haemo-Sol results!

Haemo-Sol in 1% Solution – Solution to Every Hospital Cleansing Problem.

- safe, effective, economical
- one 5 lb. can makes 80 gallons of crystal-clear solution
- costs less than 7¢ per gallon
- can be used and re-used without affecting its potency

BEST BY HOSPITAL TEST

Thousands of hospitals and laboratories throughout the world attest to Haemo-Sol's concentrated cleansing and blood dissolving properties.

Write for literature and samples

Prices per 5 lb. can.

12 cans $5.40 each

6 cans $6.08 each

1-5 cans $6.75 each

MEINECKE & COMPANY INC.

Serving The Hospitals Of America For More Than Fifty Years

225 Varick St., New York 14 • 736 E. Washington Blvd., Los Angeles 21, Calif.

Index to Products Advertised—*Continued*

ONLY HAEMO-SOL GIVES HAEMO-SOL RESULTS

Haemo-Sol is the pioneer blood-solvent cleanser specifically formulated for exacting hospital and laboratory use. With Haemo-Sol, blood dissolves, tissue, mucous and all other foreign substances *completely* disengage on immersion alone. Equally effective, safe and efficient for cleansing metal, rubber, glass, Haemo-Sol's controlled pH also eliminates any etching effect on glass, inhibits rust, prevents microscopic pitting of stainless steel. The ideal pre-sterilization technique, Haemo-Sol cleanses surgical instruments, apparatus, clinical glassware without manual scrubbing.

Because Haemo-Sol contains no harsh caustic irritants frequently found in other preparations, and is further fortified with Urea, it may be used by even those with the most tender skin, with complete safety.

Remember, only Haemo-Sol gives Haemo-Sol results!

Haemo-Sol in 1% Solution – Solution to Every Hospital Cleansing Problem.

- safe, effective, economical
- one 5 lb. can makes 80 gallons of crystal-clear solution
- costs less than 7¢ per gallon
- can be used and re-used without affecting its potency

BEST BY HOSPITAL TEST

Thousands of hospitals and laboratories throughout the world attest to Haemo-Sol's concentrated cleansing and blood dissolving properties.

Write for literature and samples

Prices per 5 lb. can.

12 cans $5.40 each
6 cans $6.08 each
1-5 cans $6.75 each

MEINECKE & COMPANY INC.

Serving The Hospitals Of America For More Than Fifty Years

225 Varick St., New York 14 • 736 E. Washington Blvd., Los Angeles 21, Calif.

WEBB & KNAPP, INC.
I. M. PEI., *director,*
architecture & planning department

KAHN & JACOBS, G. MERIDITH MUSICK
associated architects

JAROS, BAUM & BOLLES
consulting engineers

GEORGE A. FULLER COMPANY
general contractor

CRABB PLUMBING & HEATING CO.
plumbing contractor

GRINNELL COMPANY
plumbing wholesaler

Plaza opens up site area to give the three buildings greater ground floor income values

DENVER SALUTES "MILE HIGH CENTER"

• Genius has scored another win by giving Denver its new MILE HIGH CENTER—an outstanding architectural achievement of significant benefit to owners and occupants, and also a stimulant to citizenry pride. The sloping site of the "Center" is dominated by a 23-story office tower surrounded by a plaza which extends beneath it. Bordering the plaza on one side is a bank building. On the higher street level is a new airline downtown office and below it a restaurant facing the plaza. The all-glass curtain wall of the impressive office tower is interrupted only by gray cast-aluminum covering the structural columns and beams, and the off-white porcelain enamel horizontals and verticals which encase the heating and cooling system. All windows are fixed and will be washed from a traveling platform which runs up and down the face of the structure. SLOAN *Flush* VALVES, famous for efficiency, durability and economy, were selected for installation throughout Mile High Center—more evidence of preference that explains why . . .

***more* SLOAN *Flush* VALVES**
are sold than all other makes combined

SLOAN VALVE COMPANY • CHICAGO • ILLINOIS

Another achievement in efficiency, endurance and economy is the SLOAN *Act-O-Matic* SHOWER HEAD, which is automatically self-cleaning each time it is used! No clogging. No dripping. Architects specify, and Wholesalers and Master Plumbers recommend the *Act-O-Matic*—the better shower head for better bathing.

Write for completely descriptive folder